TOWER HAMLETS HEALTH AND WELLBEING BOARD

Monday, 24 March 2014 at 5.00 p.m. Committee Room MP701, 7th floor, Town Hall, Mulberry Place, 5 Clove Crescent, London, E14 2B

This meeting is open to the public to attend.

Members:	**Representing**
Chair: Mayor Lutfur Rahman	(Mayor)
Vice-Chair: Councillor Abdul Asad	(Cabinet Member for Health and Wellbeing)
Councillor Alibor Choudhury	(Cabinet Member for Resources)
Councillor Oliur Rahman	(Cabinet Member for Children's Services)
Councillor Gulam Robbani	(Executive Advisor to the Cabinet and Mayor on Adult Social Care)
Councillor Denise Jones	
Robert McCulloch-Graham	(Corporate Director, Education Social Care and Wellbeing)
Dr Somen Banerjee	(Interim Director of Public Health, LBTH)
Dr Amjad Rahi	(Healthwatch Tower Hamlets Representative)
Dr Sam Everington	(Chair, Tower Hamlets Clinical Commissioning Group)
Jane Milligan	(Chief Officer, Tower Hamlets Clinical Commissioning Group)
Co-opted Members	
Alastair Camp	(Non-Executive Director, Barts Health and Chair of the Integrated Care Board)
Sharon Hanooman	(Vice-Chair, Tower Hamlets Community Voluntary Sector)
Sue Lewis	(Chief Operating Officer, Barts Health NHS Trust)
Steve Stride	(Chief Executive, Poplar HARCA)
John Wilkins	(Deputy Chief Executive, East London and the Foundation Trust)
Mahdi Alam	(Young Mayor)

The quorum of the Board is a quarter of the membership including at least one Elected Member of the Council and one representative from the NHS Tower Hamlets Clinical Commissioning Group.

Public Questions
Before the formal business of the Board is considered, up to 15 minutes are available for public questions on any items of business on the agenda. Please send questions to the Officer below by **5pm the day before the meeting**.

Contact for further enquiries:
Zoe Folley, Democratic Services
1st Floor, Mulberry Place, Town Hall, 5 Clove Crescent, E14 2BG
Tel: 02073644877
E:mail: zoe.folley@towerhamlets.gov.uk
Web: http://www.towerhamlets.gov.uk/committee

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Role of the Tower Hamlets Health and Wellbeing Board.

- To encourage integrated working between persons who arrange for the provision of any health or social services in Tower Hamlets for the advancement of the health and wellbeing of the people in Tower Hamlets.
- To identify needs and priorities across Tower Hamlets and publish and refresh the Tower Hamlets Joint Strategic Needs Assessment (JSNA) so that future commissioning/policy decisions are based on evidence.
- To prepare the Joint Health and Wellbeing Strategy.
- To be involved in the development of any Clinical Commissioning Group (CCG) Commissioning Plan that applies to Tower Hamlets and to give its opinion to the CCG on any such proposed plan.
- To communicate and engage with local people on how they could achieve the best possible quality of life and be supported to exercise choice and control over their personal health and wellbeing. This will involve working with Local HealthWatch to make sure there's a continuous dialogue with the public to ensure services are meeting need.
- To carry out new functions as requested by the Secretary of State and as advised in guidance issued from time to time.

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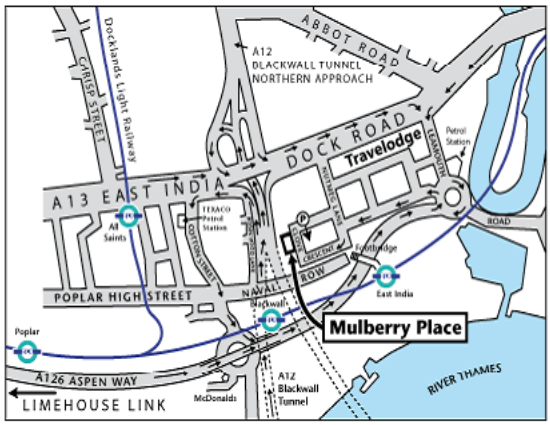

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WELCOME, INTRODUCTIONS AND APOLOGIES FOR ABSENCE

To receive apologies for absence and subsequently the Chair to welcome those present to the meeting and request introductions.

1 .1 Minutes of the Previous Meeting and Matters Arising **1 - 10**

To confirm as a correct record the minutes of the Tower Hamlets Health and Wellbeing Board held on 6th February 2014. Also to consider matters arising therefrom.

1 .2 Declarations of Disclosable Pecuniary Interests **11 - 14**

To note any declarations of interest made by members of the Board. (See attached note of Monitoring Officer).

1 .3 Forward Programme **15 - 18**

Recommendation:

To consider and comment on the Forward Programme.

Lead for item: Deborah Cohen, Service Head, Commissioning and Strategy, Education, Social Care and Wellbeing, LBTH.

2. HEALTH AND WELLBEING STRATEGY

2 .1 Clinical Commissioning Group feedback on Barts Health Inspection and Action Plan **19 - 26**

Recommendation:

To note the contents of the report and Barts Health's response to the CQC inspection and Healthwatch feedback.

Lead for Item: Sue Lewis, Chief Operating Officer, Barts Health NHS Trust.

2 .2 Tower Hamlets Clinical Commissioning Group Operating Plan and Quality, Innovation, Productivity and Prevention **27 - 52**

Recommendation: To note the report

Lead for Item: Jane Milligan, Chief Officer, Tower Hamlets Clinical Commissioning Group.

2 .3 Health and housing: workshop feedback **53 - 62**

Recommendation:

To note the contents of this paper.

Lead for Item: Louise Russell, Service Head, Corporate Strategy & Equality, LBTH.

2 .4 Transforming services, changing lives in east London **63 - 68**

Recommendations:

1. To note the date of the case for change stakeholder event (4 April 2014)

2. To consider a suitable date for a discussion on the HWBB agenda regarding the case for change.

Lead for Item: Jane Milligan, Chief Officer, Tower Hamlets Clinical Commissioning Group.

2 .5 Memorandum of Understanding **69 - 88**

Recommendations:

To NOTE:

- Progress made on the MOU (Appendix 2 and Appendix 3)
- The ongoing work between LBTH and Barts Health NHS Trust around employment
- The overlap between the MOU (especially paragraphs 7 and 8) and the work on the BCF and integration and that the MOU may be a duplication of this area of the Board's work. This will be reflected in the update referred to in the Committee Report
- That the MOU can be used as a way to maximise social value (in the sense of the Public Values (Social Value) Act 2012) and that officers will look at how to measure this more formally as a way of evaluating the success of the MOU.

To AGREE:

- That the MOU be reviewed in early 2014-15 and an update be taken to the Health and Wellbeing Board not later than July 2014 that reflects the above comments.

Lead for Item: Deborah Cohen, Service Head for Commissioning and Health, Education, Social Care and Wellbeing, LBTH.

3. REGULATORY OVERSIGHT

3 .1 Oral Health of Children 89 - 96

Recommendations

1. Promote the Council's engagement with NHS England to increase the capacity within general dental practice including the resolution of issues delaying the opening of the new dental practice at the Harford Health Centre.

2. HWBB to note importance of oral health improvement programmes for children including the school fluoride varnish programme in addressing trends in dental decay

3. Explore the possibility of including figures from the dental school primary care service in monitoring the dental access indicator.

Lead for Item: Desmond Wright, Consultant in Dental Public Health

3 .2 Better Care Fund Planning Template - TO FOLLOW

Recommendation:

Agree the final version of the Better Care Fund Planning Template (Appendix 1) before final submission to NHS England on 4 April 2014

Lead for Item: Robert McCulloch-Graham, Corporate Director, Education Social Care and Wellbeing

3 .3 Reform of Special Educational Needs (SEN): The Children and Families Bill 2013 & the Draft SEN Code of Practice 97 - 112

Recommendations:

1. Support the work of the project board and the plans to ensure that the Local Offer is underpinned by local authority and clinical commissioning group agreeing on local provision in line with the priorities of this Health & Wellbeing Board.

2. Support the implementation of the SEN Reforms by promoting the greater responsibilities on non-education services to participate.

3. Support the Joint Commissioning Plans between the Council and the CCG to secure and review the wide range of provision made across all agencies to meet the needs of children and young people with SEN.

Lead for Item: Anne Canning, Service Head, Learning and Achievement, Education, Social Care and Wellbeing, LBTH.

3 .4 Protocol in support of the relationship between the Tower Hamlets Health and Wellbeing Board, the Tower Hamlets Local Safeguarding Children Board and the Tower Hamlets Local Safeguarding Adults Board **113 - 136**

Recommendations:

1. Agree the attached Protocol in support of the relationship between the Tower Hamlets Health and Wellbeing Board, the Tower Hamlets Local Safeguarding Children Board and the Tower Hamlets Local Safeguarding Adults Board

2. Note the timescales for sharing for plans and priorities set out in the protocol and Committee report.

Lead for Item: Robert McCulloch-Graham, Corporate Director, Education Social Care and Wellbeing

4. ANY OTHER BUSINESS

To consider any other business the Chair considers to be urgent.

Date of Next Meeting – Provisional: Pending Approval at the Council meeting on 26th March 2014
Tuesday, 8 July 2014 to be held in Committee Room, 1st Floor, Town Hall, Mulberry Place, 5 Clove Crescent, London, E14 2B

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LONDON BOROUGH OF TOWER HAMLETS

MINUTES OF THE TOWER HAMLETS HEALTH AND WELLBEING BOARD

HELD AT 5.15 P.M. ON THURSDAY, 6 FEBRUARY 2014

COMMITTEE ROOM 1, 1ST FLOOR, MULBERRY PLACE,TOWN HALL, 5 CLOVE CRESCENT, LONDON, E14 2BG

Members Present:

Councillor Abdul Asad (Vice-Chair)	(Cabinet Member for Health and Wellbeing)
Councillor Alibor Choudhury	(Cabinet Member for Resources)
Councillor Denise Jones	
Robert McCulloch-Graham	(Corporate Director, Education Social Care and Wellbeing, LBTH)
Dr Somen Banerjee	(Interim Director of Public Health, LBTH)
Dr Amjad Rahi	(Healthwatch Tower Hamlets Representative)
John Wardell (Substitute for Jane Milligan)	(Deputy Chief Officer, Tower Hamlets Clinical Commissioning Group)
Dr Judith Littlejohn (Substitute for Dr Sam Everington)	(Clinical Member of Clinical Commissioing Group Governing Body and Mental Health Lead)

Co-opted Members Present:

Sue Lewis	(Chief Operating Officer, Barts Health NHS Trust)
John Wilkins	(Deputy Chief Executive, East London NHS Foundation Trust)

Others Present:

Dianne Barham	(Director of Healthwatch Tower Hamlets)
Richard Fradgley	(Deputy Director of Mental Health and Joint Commissioning, Tower Hamlets Clinical Commissioning Group/LBTH)

Officers in Attendance:

Deborah Cohen	(Service Head, Commissioning and Health, Education, Social Care and Wellbeing, LBTH)
Louise Russell	(Service Head Corporate Strategy and Equality, Directorate, Law Probity and Governance, LBTH)
David Galpin	(Service Head, Legal Services, Directorate Law Probity and Governance, LBTH)
Charlotte Saini	(Strategy, Policy and Performance Officer, Education, Social Care and Wellbeing,LBTH)

Leo Nicholas	(Strategy, Policy and Performance Officer, Education, Social Care and Wellbeing, LBTH)
Zoe Folley	(Committee Officer, Directorate Law, Probity and Governance,LBTH)

Apologies:
Councillor Oliur Rahman, Dr Sam Everington, Sharon Hanooman, Steve Stride and Jane Milligan. Councillor Denise Jones gave apologies for having to leave early.

The order of business was changed at the meeting (following items 1 -2.2) as follows: items 3.1, 3.3, 3.2, 3.4, 4.2, 4.1, 4.3, 4.4, 4.5.

For ease of reference, the order of the minutes follow the agenda order.

COUNCILLOR ABDUL ASAD (CHAIR)

Councillor Abdul Asad welcomed those present to the meeting. He reminded Members that this was the first formal meeting of the HWB that would be held in public following the establishment of the Board at Full Council in January 2014. The Chair welcomed members of the public to the meeting and also the new Members of the Board: Councillor Denise Jones, Sue Lewis (Barts Health, replacing Len Richards) Steve Stride (Housing Forum Representative, replacing Mike Tyrell). It was also noted that Councillor Rachael Saunders could attend meetings in her capacity as Chair of the Health Scrutiny Panel.

The Chair also reported on developments since the last meeting. He reported that the partnership between the Council and health providers (local Clinical Commissioning Groups, Barts Health, the East London Mental Health Trusts, Tower Hamlets, Waltham Forest and Newham Councils) had become one of three Pioneers in London in respect of integrated care. Councillor Asad welcomed this and felt that it would put the Council in a strong position in respect of the Better Care Fund.

1. DECLARATIONS OF DISCLOSABLE PECUNIARY INTERESTS

No declarations of Disclosable Pecuniary Interest were made.

1.1 Forward Programme

The Board noted the Forward Plan.

2. ITEMS FOR CONSIDERATION

2.1 Tower Hamlets Health and Wellbeing Board, Terms of Reference, Quorum, Membership and Dates of Meetings.

The Board noted the Terms of Reference report with the amendment, agreed at Cabinet and Full Council regarding the arrangements for chairing the meeting when the Mayor was absent.

Resolved:

That the Tower Hamlets Health and Wellbeing Board (HWBB) Terms of Reference, Quorum, Membership as attached to the committee report and future meeting dates be agreed with the addition of the amendment agreed by Cabinet on 4th December 2013 and approved by Council on 22nd January 2014:

- That should the Mayor be unable to attend a meeting then the Cabinet Member for Health and Wellbeing would chair the meeting in his place.

2.2 Healthwatch Update

Dianne Barham, (Director of Healthwatch Tower Hamlets) presented the summary of patient feedback on services run by Barts Health. The Board noted the positive comments around children's services, A&E and the quality of the accommodations amongst other issues. The Board also noted the concerns around administration, nurse shortages, maternity services, waiting times in A&E, the environment and incontinence services. It was noted that Healthwatch were working with community groups to improve accessibility and way finding for people with special needs. Healthwatch were also working with the CCGs and Barts Health, along with patients (through community groups) to identify and analyse the key issues.

In response, the Board stressed the need for the services to respond to the feedback. Ms Barham reported that Healthwatch were working on ways to improve the feedback process and ways of holding the services to account. It was suggested that the patient feedback could be reported to the LBTH Health Scrutiny Panel.

Sue Lewis (Chief Operating Officer, Barts Health NHS) reported on the steps being taken at Barts to address the issues such as the preparation of action plans taking into account the patient feedback and the CCG feedback. She explained that robust measures would be put in place at a corporate level to ensure the plans were driven through. She explained the specific measures that had already been taken. For example, the new front entrance for the hospital would be opening in March 2014 to improve way finding. Ms Lewis suggested that the Healthwatch feedback be included in the CCG report (subject to Healthwatch's agreement) to save her organisation having to prepare two reports.

A Member considered that staff attitudes towards patients was still an issue of concern and that the care pathway should be made more accessible. Steps should be taken to address this.

Deborah Cohen (Service Head, Commissioning and Health, LBTH) also referred to the incontinence services given the findings of the HWB 'quick start' project regarding paediatric continence and noted the underfunding in this area. It was questioned whether this issue of adult continence should be included in the CCG's 2 Year Operational Plan. Mr Wardell reported that the CCG recognised the importance of this issue. It was intended to link the incontinence services with the integrated care services for adults. The Chair requested that Healthwatch come back to the next meeting of the HWB to present their recommendations with the response from Barts Health

Resolved:

That the report be noted.

3. HEALTH AND WELLBEING STRATEGY

3.1 Tower Hamlets Mental Health Strategy

Richard Fradgley (Deputy Director of Mental Health and Joint Commissioing for the Tower Hamlets Clinical Commissioning Group and the Council) gave a detailed presentation of the strategy for the next five years. This covered the prevalence of mental health problems in the Borough and demand for the services; the recent successes in dementia care, crisis services for adults and accommodation.

The Board were advised of the steps in developing the strategy, based on community engagement, the visions, the issues and commitments for the various age groups. This included children and young people, where a key aim was increasing awareness of mental health issues in schools and access to services. The Board also considered the plans for adults and older people. It was recognised that loneliness and isolation was a key concern for older people. The Board noted the cross cutting aims such as addressing stigma and discrimination. There would be regular reports to the HWB on progress with the strategy including 'dashboards' for review by the Board.

A Member asked questions about dual diagnoses (where people presented with a mental health issue and as well as addictions) and the steps taken to address this. Mr Fradgley noted the extent of this problem as shown by the statistics. The Drugs and Alcohol Team were there to identify and deal with such issues within the mental health services.

The Board stressed the need for both the physical as well as the mental health care needs of patients to be brought together, as many patients often presented with mental health and physical problems. The Board were advised of the services offered to address this such as GP presence at mental health care centres. The service took a holistic approach to patients needs. John Wilkins (East London and the Foundation Trust) welcomed his Trust's

involvement in the strategy at an early stage. He also reported on the involvement of Barts Health clinicians in services to address the physical needs of patients.

A Member asked about the statistics. In particularly, the number of people with vascular dementia from the BME communities which made up over 50% of the community in Tower Hamlets. Certain BME communities were more at risk of Type 2 diabetes therefore were more at risk of developing vascular dementia in the long term. He sought assurances regarding the plans to address this expected rise in BME adults with vascular dementia. Mr Fradgley referred to the noticeable increase in diagnosis rates in this condition in the Bengali population, under the new service, expected to continue. Mr Fradgley welcomed the increase in earlier detection. He highlighted the work of the outreach services in raising awareness and contributing to this success.

A Member asked about the key areas for improvement and how the concerns would be addressed. Mr Fradgley noted the need to focus on particular services such as Child and Adolescent Mental Health Services and older adults, judging by the feedback.

A Member considered that crisis management was a key issue.

Mr Fradgley outlined the nature of the crisis services. There was a single point of contact in the community and home treatment services. These very effective. As a result of this, bed occupancy rates were comparatively low. The service was committed to developing a pathway to further improve this service.

In response to further questions, Mr Fradgley reported that his service would be producing a Joint Strategic Needs Assessment factsheet on mental health and crime. The service was working with the Probation Services to deliver training and would be preparing plans with the Council and hospitals to address this issue.

The Chair thanked Mr Fradgley for the presentation and for the fantastic piece of work on behalf of the Board.

Resolved:

That the Tower Hamlets Mental Health Strategy be approved.

3.2 Tower Hamlets Health and Wellbeing Strategy 2013-16

Louise Russell (Service Head, Corporate Strategy & Equality, LBTH) presented the HWB strategy and the delivery plans. The strategy had been developed through a partnership approach, consulted on and presented to the CCG Board, the Shadow HWB and endorsed by the Council's Cabinet. Formal approval of the strategy and the finalised delivery plans was now

sought from the HWB. Once approval had been given, the strategy would be formally published.

She highlighted the changes to the strategy since last reported to the Shadow HWB in September 2013, including the revised maternity and early years plan, the work to reflect the Mental Health Strategy and the developments in respect of the Better Care Fund.

Ms Russell also reported on a recent meeting with the Housing Forum to jointly take forward issues in relation to housing. The outcome of this meeting would be reported back to the HWB. Ms Russell also confirmed that the monitoring reports would be reported back to the HWB on a regular basis.

Action: Louise Russell, (Service Head, Corporate Strategy & Equality, LBTH) to report back on Housing Workshop.

Ms Russell's service would also be working with the Mental Health services to integrate the delivery of the HWB strategy and the Mental Health Strategy.

Resolved:

1. That the strategy, delivery plans, proposed outcome measures and targets be agreed.

2. That the delivery and performance monitoring arrangements be agreed as set out in section 3 of the committee report.

3.3 Joint Strategic Needs Assessment (JSNA) - Key Findings

Councillor Denise Jones left the meeting during this item at 6:15pm.

Dr Somen Banerjee (Interim Director Public Health LBTH) presented the Joint Strategic Needs Assessment (JSNA), Key Findings. Dr Banerjee gave a detailed presentation of the findings including the healthy life expectancy rates for Borough residents. The figures were some of the lowest in the county. He also explained the links between the environment, inequality and health, the key health issues facing the various age groups in the Borough and the link between the HWBs priorities and the JSNA.

Members highlighted the problems with childhood obesity. A Member stressed the need for schools and teachers to be involved in addressing the issue. Dr Banerjee stressed the value in tackling this problem at a regional and national level as per the success in New York, rather than just locally. He considered that the HWB might wish to lobby the Mayor of London and relevant regional and national bodies about this. His service was also undertaking a review of the role of school nurses in addressing this issue following the transfer of this service into local government public health.

Robert McCulloch – Graham (Corporate Director, Education Social Care and Wellbeing, LBTH) also highlighted the national campaigns and legislation to address this issue. However, he stressed the need to work directly with families to deal with this issue.

Resolved:

That the findings of the Joint Strategic Needs Assessment be noted.

3.4 Clinical Commissioning Group (CCG) Operational Plan - To Follow

John Wardell (Deputy Chief Officer, Tower Hamlets Clinical Commissioning Group THCCG) presented the report. The report outlined the approach of the CCG to the draft submission of their Operating Plan due on 14th February with the final draft due on 4th April 2014.

Mr Wardell highlighted the main sections of the operating plan submission including: the plans for self-certification, improving outcomes through a benchmarking cohort, the quality premium, the local metric and the medium term financial plan.

It was intended that the final draft would be submitted to the next meeting of the HWB in March 2014 for discussion prior to the final submission.

Resolved:

1. That the report be noted:

2. To commit to receiving an update at the next Board Meeting in March 2014 ahead of the final submission on 4th April 2014.

4. REGULATORY OVERSIGHT

4.1 Better Care Fund

Deborah Cohen (Service Head for Commissioning and Health, LBTH) presented the report regarding the Better Care Fund (BCF). It was noted that the funding pooled together existing funding streams, for health and social care services, shared between the NHS and local authorities to deliver better outcomes for older and disabled people. Ms Cohen considered that any criteria for access to these services should be applied flexibly bearing in mind that certain conditions that are associated with older people have an earlier onset in the Borough.

Local Authorities and CCGs were required to submit the first draft of the planning template to the LGA and NHS England by 14th February 2014. It was

intended that the draft (in the agenda papers) would be the submission for this first deadline.

It was required that the final version be submitted by 4th April 2014. As a result, the proposal would be brought back to the HWB at its next meeting (24th March 2014) for consideration and final approval. The Board were therefore invited to submit their comments outside the meeting to Deborah Cohen as soon as possible for consideration at that meeting

There would also be a workshop on the matter after the HWB meeting in March.

The Board also noted the draft finance, outcome and matrix sections. It was possible that part of the funding in future years may be based on performance against the chosen matrix. Further details of these sections would be reported to the Board at its meeting in March.

Resolved:

That the draft Better Care Fund Planning Template be submitted to the LGA and NHS England

4.2 Adults Health and Wellbeing Board -Section 256 Funding 2013-14

Deborah Cohen (Service Head, Commissioning and Health, LBTH) presented the report, following consideration by the Shadow HWB in September 2013.

The report outlined the funding available to LBTH in 2013/14 and the proposals agreed between the Council and Tower Hamlets, CCG on how the funding should be spent to support local needs.

The report was before the Board for formal sign off which was a pre-condition to the NHS England signing the funding agreement.

Resolved:

1. That the requirements of the transfer from NHS England to LBTH be noted.

2. That the spending plans for the 2013/14 allocation be approved as agreed between Tower Hamlets Clinical Commissioning Group and London Borough of Tower Hamlets, as detailed in Appendix 1 of the committee report.

4.3 Disabled Children's Charter

Robert McCulloch-Graham (Corporate Director, Education Social Care and Wellbeing, LBTH), introduced the report regarding the Disabled Children's

Charter. The paper explained how the Council and its partners meets the Charter, through the Children and Families Partnership Board (CFPB) and recommended that the HWB sign up to the charter.

It was confirmed that the report had been considered by the CFPB.

Resolved:

1. That the position statement in relation to each of the commitments in the Charter be noted and it be agreed that the Tower Hamlets Partnership sign up to the Charter;

2. That the Joint Strategic Needs Assessment attached as an appendix to the committee report be noted.

4.4 Winterbourne Actions - Update report to HWBB

Deborah Cohen, (Service Head for Commissioning and Health, Education, Social Care and Wellbeing, LBTH) presented the report.

It was noted that Tower Hamlets made limited use of assessment and treatment centres outside of the Borough. Nevertheless, Tower Hamlets had reviewed all people placed in such placements in compliance with the Winterbourne actions. A list of the actions taken and the outcomes were included in the report.

Resolved:

To note the Tower Hamlets compliance with the Winterbourne actions and to receive annual updates on future review activity related to people in assessment and treatment centres and the longer term development of local housing and care support.

4.5 2013 Adult Autism Self-Assessment Framework (SAF)

Deborah Cohen (Service Head for Commissioning and Health, Education, Social Care and Wellbeing, LBTH) presented the report regarding the Self-Assessment Framework (SAF). The Board noted a copy of the SAF (attached to the report) with a summary of progress in specific areas.

The Board noted the steps to secure a provider to deliver an adult diagnosis and intervention service for the Borough. The Board welcomed the decision taken by the Cabinet yesterday (5th February 2014) to award the contract to a provider and considered that this was a major step forward.

Action: Louise Russell, Service Head, Corporate Strategy & Equality, LBTH)

Resolved:

1. That the content of the report and the final Autism Self-Evaluation document (provided as Appendix One) be noted.

2. That the questions contained within Appendix Two be included in the quarterly HWB performance reports.

Action: Louise Russell, Service Head, Corporate Strategy & Equality, LBTH)

5. ANY OTHER BUSINESS

There was no other business.

The meeting ended at 7.00 p.m.

Vice - Chair, Councillor Abdul Asad
Tower Hamlets Health and Wellbeing Board

DECLARATIONS OF INTERESTS - NOTE FROM THE MONITORING OFFICER

This note is for guidance only. For further details please consult the Members' Code of Conduct at Part 5.1 of the Council's Constitution.

Please note that the question of whether a Member has an interest in any matter, and whether or not that interest is a Disclosable Pecuniary Interest, is for that Member to decide. Advice is available from officers as listed below but they cannot make the decision for the Member. If in doubt as to the nature of an interest it is advisable to seek advice **prior** to attending a meeting.

Interests and Disclosable Pecuniary Interests (DPIs)

You have an interest in any business of the authority where that business relates to or is likely to affect any of the persons, bodies or matters listed in section 4.1 (a) of the Code of Conduct; and might reasonably be regarded as affecting the well-being or financial position of yourself, a member of your family or a person with whom you have a close association, to a greater extent than the majority of other council tax payers, ratepayers or inhabitants of the ward affected.

You must notify the Monitoring Officer in writing of any such interest, for inclusion in the Register of Members' Interests which is available for public inspection and on the Council's Website.

Once you have recorded an interest in the Register, you are not then required to declare that interest at each meeting where the business is discussed, unless the interest is a Disclosable Pecuniary Interest (DPI).

A DPI is defined in Regulations as a pecuniary interest of any of the descriptions listed at **Appendix A** overleaf. Please note that a Member's DPIs include his/her own relevant interests and also those of his/her spouse or civil partner; or a person with whom the Member is living as husband and wife; or a person with whom the Member is living as if they were civil partners; if the Member is aware that that other person has the interest.

Effect of a Disclosable Pecuniary Interest on participation at meetings

Where you have a DPI in any business of the Council you must, unless you have obtained a dispensation from the authority's Monitoring Officer following consideration by the Dispensations Sub-Committee of the Standards Advisory Committee:-

- not seek to improperly influence a decision about that business; and
- not exercise executive functions in relation to that business.

If you are present at a meeting where that business is discussed, you must:-

- Disclose to the meeting the existence and nature of the interest at the start of the meeting or when the interest becomes apparent, if later; and
- Leave the room (including any public viewing area) for the duration of consideration and decision on the item and not seek to influence the debate or decision

When declaring a DPI, Members should specify the nature of the interest and the agenda item to which the interest relates. This procedure is designed to assist the public's understanding of the meeting and to enable a full record to be made in the minutes of the meeting.

Where you have a DPI in any business of the authority which is not included in the Member's register of interests and you attend a meeting of the authority at which the business is considered, in addition to disclosing the interest to that meeting, you must also within 28 days notify the Monitoring Officer of the interest for inclusion in the Register.

Further advice

For further advice please contact:-

Meic Sullivan-Gould, Monitoring Officer, Telephone Number: 020 7364 4801

APPENDIX A: Definition of a Disclosable Pecuniary Interest

(Relevant Authorities (Disclosable Pecuniary Interests) Regulations 2012, Reg 2 and Schedule)

Subject	Prescribed description
Employment, office, trade, profession or vacation	Any employment, office, trade, profession or vocation carried on for profit or gain.
Sponsorship	Any payment or provision of any other financial benefit (other than from the relevant authority) made or provided within the relevant period in respect of any expenses incurred by the Member in carrying out duties as a member, or towards the election expenses of the Member. This includes any payment or financial benefit from a trade union within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992.
Contracts	Any contract which is made between the relevant person (or a body in which the relevant person has a beneficial interest) and the relevant authority— (a) under which goods or services are to be provided or works are to be executed; and (b) which has not been fully discharged.
Land	Any beneficial interest in land which is within the area of the relevant authority.
Licences	Any licence (alone or jointly with others) to occupy land in the area of the relevant authority for a month or longer.
Corporate tenancies	Any tenancy where (to the Member's knowledge)— (a) the landlord is the relevant authority; and (b) the tenant is a body in which the relevant person has a beneficial interest.
Securities	Any beneficial interest in securities of a body where— (a) that body (to the Member's knowledge) has a place of business or land in the area of the relevant authority; and (b) either— (i) the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body; or (ii) if the share capital of that body is of more than one class, the total nominal value of the shares of any one class in which the relevant person has a beneficial interest exceeds one hundredth of the total issued share capital of that class.

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Health and Wellbeing Board Forward Plan

	Report Title	Lead Officer	Reason for submission	Time
Date: 24 March 2014				
Public Questions	Public Questions			
Standing Items	Apologies & Substitutions Minutes & Matters Arising Forward Plan			
Health and Wellbeing Strategy	CQC Feedback on Barts Health inspection	Sue Lewis		
	CCG operating plan	Jane Milligan		
	Health and Housing: Workshop feedback	Louise Russell		
	Transforming Health, Improving Lives	Jane Milligan		
	MOU	Deborah Cohen		
	Dental Services	Desmond Wright		
Regulatory Oversight	Better Care Fund	Deborah Cohen	Final draft must be submitted by end of March	
	SEN Reforms	Anne Canning /David Carroll		
	Protocol in Support of the HWBB, LSCB and Safeguarding Adults Board	Deborah Cohen	agreed to develop a protocol at the Sept 30 2013 Board	
Date: July 2014				
	Report Title	**Lead Officer**	**Reason for submission**	**Time**
Public Questions	Public Questions			
Standing Items	Apologies & Substitutions Minutes & Matters Arising Forward Plan			
Health and Wellbeing Strategy	Assistive Technology	Deborah Cohen/Robert Driver		
	Commissioning of Primary Care services	Vanessa Lodge	postponed from March	
	HWBS Year End Reporting	Louise Russell		
	Maternity Services	Judith Littlejohns and Catherine Platt	moved from March	
Regulatory Oversight	Local Account	Deborah Cohen/Karen Sugars		

Health and Wellbeing Board Workshop Forward Plan

Date: New Year 2014, 15:00 - 17:00, Room TBC				
	Report Title	**Lead Officer**	**Reason for submission**	**Time**
4th February 2014	Health and Housing	Louise Russell		1hr 30mins
Date: tbc in Spring 2014, 15:00 - 17:00, Room TBC				
	Report Title	**Lead Officer**	**Reason for submission**	**Time**
	Better Care Fund Workshop	Deborah Cohen		
	Assistive Technology	Robert Driver		

Date: 26th February 2014				
	Report Title	**Lead Officer**	**Reason for submission**	**Time**
Standing items	Apologies & Substitutions Minutes & Matters Arising	DC		
	Board Becoming Statutory	DC		
	Forward Plan (Board, EOG, Workshops)	DC		
Board preparation	March board preparation	DC	Review first public HWBB and March HWBB papers	
	CCG operating plan/commissioning intentions	Jane Milligan		
	MOU	DC		
	Primary Care services commissioning	Vanessa Lodge		
	Better Care Fund - Governance	DC		
	LGA HWBB peer challenge	DC		
	Health and Housing workshop	LR		
	Young Mayor Projects	CS/LN		
	Time to Change subgroup			
	Safeguarding Protocol	DC		

Date: April 2014				
	Report Title	**Lead Officer**	**Reason for submission**	**Time**
Standing items				
Board preparation				
Information item				

Health and Wellbeing Board - Items to be scheduled

Board/Workshop/EOG	Suggested meeting date	Report Title	Lead Officer	Reason for submission	Time
Board	After Somen meets Jane (december?)	Olympics Legacy -convergence Report	Jane O'Connor		
Board	February/March	Liver Disease	Somen Banerjee		
Board	After May 2014	Interface between schools and health	Robert McCulloch - Graham		
Board	July/September	Drugs and Alcohol needs assessment	Chris Lovitt		

Health and Wellbeing Board 24 March 2014	Tower Hamlets Health and Wellbeing Board
Report of: Barts health NHS Trust	**Classification:** Unrestricted
Report to Tower Hamlets Health and Wellbeing Board on our response to the CQC	

Contact for information	Sue Lewis, Chief Officer, Barts Health NHS Trust

Executive Summary

This report highlights Barts Health NHS Trust's response to the CQC inspection of all the trust's hospital sites in November 2013. Following on from the inspection the trust has developed six actions plans which detail how the trust will address issues raised during and after the inspection.

Recommendations:

The Health and Wellbeing Board is recommended to:

1. To note the contents of the report and Barts Health's response to the CQC inspection and Healthwatch feedback.

1. DETAILS OF REPORT

1.1. Report attached.

2. FINANCE COMMENTS

2.1. N/A

3. LEGALCOMMENTS

3.1. N/A

6. IMPLICATIONS TO CONSIDER

6.1. N/A

Appendices

- None

Barts Health NHS
NHS Trust

Report to Tower Hamlets Health and Wellbeing Board on our response to the CQC

24 March 2014

1. Introduction

Barts Health NHS Trust was chosen by the CQC as one of the first organisations to be reviewed under the proposed CQC Chief Inspector of Hospitals New Inspection regime. The CQC ran a pilot phase of the new regime in autumn and winter 2013, and it was preceded by the allocation of a risk rating for each NHS organisation in England. A risk ratingof 2 (high) was given to Barts Health, based on issues with cancer patient experience, accident and emergency waiting times, staff survey results, never events and outcomes of previous inspections.The Trust has always had consistently low mortality rates.

2. Background

Barts Health was inspected under the new CQC regime during November 2013. In preparation for the intensive inspection, the Trust focused on finding and fixing issues around cleaning; environment and equipment standards; well-organised and documented appraisals; regular team meetings for staff and driving a culture of open communications.

Peer reviews, made up of Barts Health staff members from nursing, infection control and facilities, supported by external representatives (including patient experience and CCG representatives) worked closely with services across all Trust sites. All staff received information CQC about what to expect and how they would be involved.

3. Summary of the CQC reports

The CQC's reports, published on 14 January 2014, recognised our challenges, the progress we have already made and areas of good practice. The reports underlined the care, commitment and compassion of our staff, and crucially, they highlighted where we needed to improve. Progress had already been made, as the CQC acknowledged by removing the three warning notices issued at Whipps Cross last year. Other previously requested improvements had also been made, including the swift replacement of broken equipment. The Trust hassince been redoubling our efforts to address the compliance requirements and other improvements set out in the reports.Specifically, the CQC found the following positive findings for our sites within Tower Hamlets, including:

- **The Royal London**
    - Emergency Assessment (EA) model
    - Ready availability of interventional radiology – patients requiring interventional radiology receive this within an hour of the need being identified and the service is available 24 hours a day, seven days a week.
    - Development opportunities available for medical records staff.
    - Staff are supported to gain specialist knowledge and experience which is beneficial for patients.

- Staff are kind, caring and attentive to patient needs

- **St Bartholomew's**
  - Patients are treated with dignity and respect and are involved in decisions about their treatment and care.
  - Staff are committed to providing good standards of care in all circumstances.
  - Staff are caring and compassionate, polite and kind in their interactions with patients, visitors and colleagues.
  - Services are well-led and staff use quality and performance information to improve

- **London Chest**
  - Staff are focused on safety and there are good examples of improving this further, such as care for people at risk of falling.
  - Staff treat patients with dignity, respect and compassion.
  - Staff are clear about their responsibilities and support each other well

- **Mile End**
  - Staff promote a culture of safety - assessing, identifying and taking action to mitigate risks.
  - Staff are polite, caring and professional in their interactions with patients.
  - Patients were protected from the risks of infection and the medical wards are clean.
  - Staff are focused on making sure patients receive good quality, safe services.

A Barts Health quality summit washeld with the CQC on 10 January, involving senior Trust representatives and key external stakeholders (CCG, CSU, NDTA, NHSE, Healthwatch, and local authority partners). Following this event, it was jointly agreed that the Trust would hold four local site summits during week commencing 3 February (see section 4).

As part of our response to the reports, the Trust hasdeveloped six action plans which detail how we will address the issues raised during and after the inspection. There is a single high level plan covering Trust wide actions and five site-specific plans covering actions at our individual hospitals.

Trust wide actions include:

- Ensuring staffing levels meet patients' needs in medical and surgical wards
- Ensuring our risk registers are managed effectively
- Improving staff morale, staff engagement and visible leadership
- Ensuring equipment is readily available when needed
- Ensuring learnings from incidents and never events are shared with all staff
- Providing 24/7 consultant cover

Our plans have now been agreed by the CQC, the Trust Development Authority and our Board.

The attached presentation also provides an overview of our key areas of reflection, learning and action. The Trust welcomes the opportunity to seek the input of the Health and Wellbeing Board to shape its response to the inspection.

4. Feedback from the local site summits

Four site summits were held in February involving a wide variety of Trust staff and external stakeholders. At each summit Seaton Giles from the CQC gave a high level summary of the inspection process and Peter Morris summarised the overall findings for Barts Health. Peter described the assessment as "tough but fair". He noted that the lead for the inspection from NHS England, Dr Andy Mitchell, had identified specific areas of service excellence that were outstanding and that the commitment and passion of our staff to serve the people of East London was evident. Each site was then presented with their specific findingsand staff were asked to consider in groups the key concerns that emerged from the reports (see appendix 1 for discussion topics) and what needs to done across the Trust and on the site to address them.

The key themes which emerged from the four site summits were:-

- Visible leadership
- Site teams versus Clinical Academic Group (CAG) teams (relationships/partnership working)
- Partnership working with CCGs and how this can be more effective, particularly in relation to Integrated Care Pathways
- Empowering staff at all levels
- Accountability, responsibility and trust (clarity of individual roles and the tiers within the CAGs)

In respect of our sites in Tower Hamlets (The Royal London, Mile End and The London Chest hospitals) and for cancer patients, the feedback was:-

- Staff engagement
  - There is less opportunity for informal corridor chat
  - Use of open door policy, accessible meetings on regular basis
  - Raising profile of executive team
  - Meetings are 'enforced' on Fridays which reduces people's ability to be visible
  - Feedback sessions on the Datix incident reporting system and root cause analysis needs to be enhanced at a local level
  - Consultation process poorly handled, massive impact on senior staff (band 6 & above)
  - Education and training, cross site rotational working, appraisal mixed review
  - Challenge of communications across all sites – use of teleconference, photo boards, who's who

- Patient Flow
  - Reduce numbers by redirecting, back door flow
  - Neuro unit rehab flow, tracheostomy patients
  - Discharge planning
  - 24 hours working eg. pharmacy and other support functions
  - Movement of managers within the trust

For St Bartholomew's, feedback included:

- Staff engagement
  - Sense of community which should be capitalised on
  - Feeling detached from the wider Trust

- Positive about visibility of executive team but need more from other levels and out of hours
- Board to ward conversations need to be focused differently
- Challenge of communications across all sites – use of teleconference, photo boards, who's who
- Need for network meetings, specifically for nursing.

- Patient engagement
  - Bottom up approach managing complaints following approach taken by the surgery CAG i.e. sharing with ward and clinical team (encourage local resolution)
  - Named consultant per ward supported – will act as a quality lead working with the ward manager

The recommendations we are taking forward from the site summits in particular are:

- To enhance visibility of all senior managers at various levels on a weekly basis, ensuring conversations are shared as appropriate.
- For the CAG Tier 1 teams to lead on the CQC conversation, ensuring compliance to the standards are met and service improvement continues with support from corporate services.
- For the CAG Tier 1 and senior managers to triangulate the discussions also relating to the Francis report action plans. Link to cultural changes.
- Senior Nurse Network meetings to be re-established post consultation

Appendix 1

Site summits - Topics for group discussion
Staff engagement and morale
Visible executive leadership
Culture – bullying harassment, raising concerns
Embedding CAG structures and development of CAG relationships with stakeholders
Strengthening site based leadership
Patient flow and discharge
Preventing hospital attendances and admissions
Facilitating early/complex discharges

Patient engagement and experience
Improving complaints handling
Hearing the patient's voice
Patient panels and working in partnership
For each:
What do we need to do consistently (i) across the Trust, and (ii) specifically on this site?
What can you as a leader or partner do to help us achieve the improvement

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Health and Wellbeing Board 24th March 2014	Tower Hamlets Health and Wellbeing Board
Report of: Tower Hamlets Clinical Commissioning Group	**Classification:** Unrestricted
Operating Plan and QIPP	

Contact for information	Josh Potter – Head of Transformation and Integration – Tower Hamlets CCG josh.potter@towerhamletsccg.nhs.uk

Executive Summary

- Each year the CCG is required to submit an Operating Plan to NHS England. The Operating Plan outlines the key actions and outcomes the CCG expects to achieve that align to NHS England's key priorities as outlined in the annual Operating Framework. The CCG has submitted a draft submission on the 14th February, with a final draft due on the 4th April.
- This paper also contains a summary of the draft Better Care Fund submission approved by the CCG executive in January
- Tower Hamlets CCG seeks to make improvements by developing programmes that focus on Quality, Innovation, Productivity and Prevention (QIPP).
- Our plan shows us working towards improvements on key outcomes, and achieving our planned surpluses over the next two years
- The CCG Governing Body signed off the operating plan and QIPP as part of the NHSE assurance process at the March Governing Body

Recommendations:

The Health and Wellbeing Board is recommended to:

Note the report

1. DETAILS OF REPORT

Each year the CCG is required to submit an Operating Plan to NHS England. The Operating Plan outlines the key actions and outcomes the CCG expects to achieve that align to NHS England's key priorities as outlined in the annual Operating Framework. The CCG has submitted a draft submission on the 14th February, with a final draft due on the 4th April.

There are four main sections to the Operating Plan submission:

1) Self-certification on key themes of quality
2) Trajectories for improved outcomes
3) Trajectories for measurement of the Quality Premium, including the identification of a local metric

The CCG is also required to submit a finance return giving a medium term financial plan over the next two years (see QIPP)

2. FINANCE COMMENTS

NA. The paper shows how the QIPP plans attach ensure delivery of planned surplus over the next two years

3. LEGALCOMMENTS

NA

6. IMPLICATIONS TO CONSIDER

NA

Appendices
None

Operating Plan

Background

Each year the CCG is required to submit an Operating Plan to NHS England. The Operating Plan outlines the key actions and outcomes the CCG expects to achieve that align to NHS England's key priorities as outlined in the annual Operating Framework. The CCG has submitted a draft submission on the 14th February, with a final draft due on the 4th April.

There are four main sections to the Operating Plan submission:

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2) Trajectories for improved outcomes

3) Trajectories for measurement of the Quality Premium, including the identification of a local metric

The CCG is also required to submit a finance return giving a medium term financial plan over the next two years (see QIPP)

Operating Plan Submissions:

1) **Self-Certification**

The CCG is asked to commit to submitting plans in April than assure:

Self-Certification	Response
Delivery of the NHS constitution:	**Tower Hamlets CCG have informed NHS England that our plans will aim to deliver these targets.** Along with all CCGs commissioning Barts Health, we are committed to ensuring quality services for patients and delivering sustainability in achieving performance standards. Barts Health and the commissioning CCGs have developed an improvement plan for 18 weeks RTT that will clear the admitted backlog against specifically agreed trajectories before end March 2014 for each specialty, with the exception of Trauma & Orthopaedics (T&O). Major service changes are being implemented and specialty level improvement plans are also being developed. A trajectory for RTT is being developed and will be finalised when RTT data validation has been completed.
That provider Cost Improvement Plans (CIPs) are deliverable and will not damage quality:	**Tower Hamlets CCG has informed NHS England that it cannot currently be assured of this, although we expect this to change in time for the final submission in April.** Guidance from NHS England states that there is an expectation that there will be functional and on-going assurance with providers about their CIPs. NHS England clarified that this would be on the totality of the CIP programme, along with more in depth oversight of large or higher risk schemes, rather than a review of each CIP line by line. It is a provider responsibility to assure that the CIPs schemes do not adversely affect the quality and safety of care provided and to provide assurance to the CCGs that their governance processes are robust and the impact of quality and safety is being closely monitored. A number of assurance meetings have taken place between Barts Health

	Executive Directors and CCG Chief Officers and Quality Leads in order to be assured that robust governance processes are in place for the assessment of CIP schemes. Regular updates at the Barts Health CQRM have highlighted the key risks for each CAG in delivering their CIPs and the potential quality impact this may have.
No MRSA in both 2014/15 and 2015/16:	**Tower Hamlets CCG has informed NHE England that we plan to achieve this.** MRSA cases are monitored via daily health care associated infection (HCAI) reports from Barts Health to facilitate real time reporting. All cases are subject to a post infection review (PIR). PIRs are reviewed and actions from provider are quality assured. The CQRM will continue to monitor implementation of learning identified through oversight of the infection control strategy and annual work plan. Representatives from the CAGs attended the CAG specific BH CQRMs to present progress to date. There is a zero tolerance threshold for MRSA. The number of MRSA cases reported by Barts Health is significantly less than the previous year and have been across different sites, therefore there have been no clearly identified patterns. East London Foundation Trust (ELFT) should also have a zero tolerance for MRSA.

2) Improving Outcomes

Tower Hamlets CCG is required to provide 5 year trajectories for 5 key outcomes:

- Potential Years of Life Lost
- Quality of Life for people with LTCs
- Reducing emergency admissions
- Positive experience of hospital care
- Positive experience of out of hospital care

For the February Submission the CCG set trajectories so that we achieve our cohort average over the next five years. For those indicators where we exceed the current cohort average, we will submit statistically significant further improvements over the next 5 years.

Who are the CCGs comparators? The comparator group identified in NHS England's 'Commissioning for Value' benchmarking information:	
Central Manchester	Camden CCG
Birmingham South and Central	Sandwell and West Birmingham
Hounslow	Brent

Leicester City	Ealing
Waltham Forest	Redbridge

Indicator	Moving towards:		13/14	14/15	15/16	16/17	17/18	18/19
	Stat significant improv	CfV average						
Potential Years of Life Lost		✓	2848.2	2754.8	2661.4	2568	2474.6	2381.2
Improving quality of life for people with LTCs (average EQ-5D score)		✓	70.30	70.74	71.18	71.62	72.06	72.50
Reducing emergency admissions composite indicator	✓		1117.0	1071.0	1025.0	979.0	933.0	887.0
Proportion of people experiencing poor inpatient care		✓	192.0	182.5	178	173.5	169.2	165
Proportion of people experiencing poor experience of GP and community care	✓		9.80	11.80	11.05	10.30	9.55	8.80

For details on indicators and metrics, please see NHS England technical guidance

3) Quality Premium

NHS England have prescribed the following to make up the CCG's quality premium payment in 2014/15-2015/16:

- Potential Years of Life Lost 2014/15 and emergency admissions
- IAPT entering treatment: to achieve an IAPT access target of 15%
- Meeting the Friends and Family Standards
- Meeting national standards for the reporting of medication errors' standards

Tower Hamlets CCG's trajectories for achievement of these standards are:

PYLL

	PYLL (Rate per 100,000 population)
2014/15	2754.8

Emergency admissions

	Emergency admissions composite indicator
Q1 2014/15	**1106.0**

Q2 2014/15	**1094.0**
Q3 2014/15	**1083.0**
Q4 2014/15	**1071.0**

Improving Access to Psychological Therapies (IAPT)

	The number of people who receive psychological therapies	The number of people who have depression and/or anxiety disorders (local estimate based on National Adult Psychiatric Morbidity Survey 2000)	Proportion
Q1 2014/15	**1030**	**31205**	3.3%
Q2 2014/15	**1170**	**31205**	3.7%
Q3 2014/15	**1170**	**31205**	3.7%
Q4 2014/15	**1302**	**31205**	4.2%
2015/16	**4993**	**31205**	16.0%

Friends and Family

Tower Hamlets CCG expects to meet the national standards for Friends and Family. The CSU Quality team report on current performance to CCGs in integrated quality and performance reports. National guidance on FFT response rates are followed and reported upon by the Clinical Quality Assurance Manager who provides interpretation on the data and commentary in monthly reports.

Medication Errors

The current medication reporting rate for Barts Health is 8.7%. The average for acute trusts in London is 10.8%. The CCG have agreed that the target for 14/15 should be 10.8%. The CCG agreed that for this year it was important for the acute trust to reach the average for similar trusts. This will be a stretch but an achievable rate of reporting for Barts Health. It is a planned that this target will be fully met by Q4 2014/15.

Local Quality Premium Outcome

Tower Hamlets CCG will continue to use the 2013/14 Quality Premium metric:

- People streamed from A+E Department to Urgent Care Centre or back to Primary Care by GP streaming initiative. 10,000 pts per annum.

We will continue with this metric because:

- Contributes towards the achievement of 4 hour wait for Barts Health
- Focused on patients receiving the right care at the right place
- Aligns to CCG prospectus

Other Information

Tower Hamlets CCG have also provided the following information to NHS England

Trajectory for C-Diff infections

	2014									2015			2014/15 Total
	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Number of C.Diff infections	4	3	4	4	3	4	4	3	4	4	3	4	44

For the year 2012/13 the trust specific threshold was 99 cases and there were 88 confirmed cases). For the year 2013/14 the threshold is 75 cases for the year. As of 12/12/13 the total number of cases for Barts Health is 49 against a trajectory of 56.25 at the end of December 2013.

The annual threshold (Objective) for CCGs is determined by NHS England, for 2014/15 this is due to be published in early 2014.

CCG has yet to receive the ambition for CDiff for 14/15 and will ensure that the template is updated appropriately for the next submission once this has been clarified.

Dementia Diagnosis Rate

	Number of people diagnosed	Prevalence of dementia	% diagnosis rate
2014/15	766	1142	67
2015/16	800	1142	70

Level of IAPT Recovery

	The number of people who have completed treatment having attended at least two treatment contacts and are moving to recovery (those who at initial assessment achieved "caseness" and at final session did not)	(The number of people who have completed treatment within the reporting quarter, having attended at least two treatment contacts) minus (The number of people who have completed treatment not at clinical caseness at initial assessment)	% recovery rate
2014/15	703	1404	50.1%
2015/16	719	1432	50.2%

Feedback from First Submission

The following changes will be made to the Operating Plan submission will be made since receiving feedback from NHS England:

- A revised CDIFF trajectory will be submitted that meets national guidance which was published after the first deadline
- Growth assumptions for activity will be revised

Tower Hamlets CCG Improvement Plans (QIPP)

Context

The context within which we develop our improvement plans is articulated in the Tower Hamlets CCG Prospectus http://www.towerhamletsccg.nhs.uk/THCCG%20prospectus%202013_v8_singles.pdf, and is based on information drawn from the JSNA, performance and quality data and patient feedback. In short Tower Hamlets has:

- High levels of health need and health inequalities
- Some of the highest premature death rates for the major killers in England and London
- High burden of long term conditions and co-morbidity
- Particular performance issues in some of our main providers e.g. 18 week waits, Cancer waits, A&E performance.
- A financial challenge estimated at £21m over the next two years

Tower Hamlets CCG seeks to make improvements by developing programmes that focus on Quality, Innovation, Productivity and Prevention (QIPP).

What are QIPP Schemes?

QIPP stands for Quality, Innovation, Productivity and Prevention

The NHS is tasked with using these areas as a guide on how to approach the challenge of delivering high quality services within a shrinking financial settlement. By focusing on improvement, the NHS can therefore ensure that when it is able to reduce spend, that is due to an improvement in quality of the system. For example:

Tower Hamlets has recently been shortlisted for a BMJ award on the use of peer support and education with GPs as a way of ensuring high quality referrals. This means that GPs are supported to manage as many conditions as possible in the community, and make sure that referrals to hospital are only made when necessary.

- This improves **Quality**, because the standard of service in general practice improves, and also means that patients are seen by the right person at the right time.
- It is **Innovative**, as most areas were pursuing triage and referral management centres (since shown to be ineffective).
- It improves **Productivity**, as the NHS is able to deliver more acute services to those that need them, without additional investment.
- It also aids **Prevention**, by making sure that conditions are managed in a timely manner, closer to the patient. It also prevents longer waiting times for acute services

It has also kept referrals to hospital lower than most comparator CCGs, which means the CCG only spends money on people who need to be in hospital. Therefore by pursuing QIPP, the CCG is able to save money, and improve services

Tower Hamlets CCG process for development of QIPP Schemes

Tower Hamlets CCG uses the following process for the development and sign off of improvement plans.

Stage	Timescale	Complete?
Needs assessment and analysis	January – April	
Development of plans within working group	April – October	
Engagement with key stakeholders	April – October	
Commissioning Intentions Produced	October	
Approval of Plans by Transformation and Innovation Committee	October - February	
Contract negotiations with providers	Jan - April	
Ratification of proposals by CCG Governing Body	March	
Implementation	April	

All plans have been signed off by the Transformation and Innovation Committee (TIC) following the development of full business cases. These cases were presented to TIC by the Clinical Governing Body Lead, and the transformation manager. On the 4th March these proposals were given formal approval by the CCG Governing Body.

Engagement

The CCG has committed to extensive engagement in the development of plans. Examples of engagement in our plans include (full details can be found in individual business cases):

- CCG Public Event at the Whitechapel Ideas Store
- The LTC working groups have representation from general practice (GP Clinical lead), public health, Barts Health services and in most cases user representatives. Where specific projects impact on a wider group of stakeholders- participation is sought from the relevant groups.
- Commissioned Urban Inclusion to run a series of discovery interviews for those receiving integrated care
- A series of road-shows for patients and provider partners to explain Integrated care and to collect views on how the system could work together
- Voluntary sector organisations such Age UK, MIND, Linkage Plus, play a pivotal role in providing local community services suitable for patients within the integrated care target group. A series of conversations with these groups provides a forum to collect their views around the proposals being proposed.
- Healthwatch was commissioned to undertake a small sample of parent /carer interviews (either face to face or via telephone) for each of the five services focused on in the Children's strategy.

Our plans

Tower Hamlets improvement plans build on the strategy that is outlined in the Prospectus. The below table gives a summary of the programmes for 2014/15, the key outcomes, and the investments and savings attached to each programme.

Programme	Key Outcome	2014/15		2015/16	
		Investment (£000s)	Savings Year (£000s)	Investment (£000s)	Savings Year (£000s)
Maternity	Improved quality	20	0	20	0
Children and Young	Comprehensive, quality	397	0	352	0

People	services				
Urgent Care	Improved A&E performance	0	46	0	46
Achieving Excellence in Primary Care	Reduce variation in quality of care	564	150	170	150
Prescribing	Reduced spend	1634	2662	3084	4084
Community Health Services	Improved quality of services	466	700	466	1100
Planned Care	Management of acute activity	120	3649	90	6358
Mental Health	Improvement in mental health services and user experience	1146	1140	646	1140
Long Term Conditions	Improved health outcomes	100	177	33	561
Integrated Care	Reduction in emergency admissions	1382	4924	1588	6183
Cancer	Improved performance	0	0	TBC	TBC
Last Years of Life	More people die in a place of their choice	0	0	TBC	TBC
Other Schemes	NA	134	106	84	202

Total		5973	13554	6563	19824
NET		7581		13111	

Alignment of QIPP Plans to the Health and Wellbeing Strategy

As with the CCGs plans for 2013/14, the QIPP plans as part of this operating plan have clear alignment to the Health and Wellbeing Strategy as articulated below:

CCG Programme	Key Outcome	Health and Wellbeing Strategy Priority			
		Maternity and Early Years	Healthy Lives	Mental Health and Wellbeing	Long Term Conditions and Cancer
Maternity	Improved quality	■	■	■	
Children and Young People	Comprehensive, quality services	■	■		■
Urgent Care	Improved A&E performance	■			
Achieving Excellence in Primary Care	Reduce variation in quality of care	■	■	■	■
Prescribing	Reduced spend	■		■	■
Community Health Services	Improved quality of services	■	■		■
Planned Care	Management of acute activity		■		■
Mental Health	Improvement in mental health services and user experience	■	■	■	■
Long Term Conditions	Improved health outcomes		■	■	■
Integrated Care	Reduction in emergency admissions		■	■	■
Cancer	Improved performance				■
Last Years of Life	More people die in a place of their choice		■	■	■
Other Schemes	NA				

The Health and Wellbeing Action plan has been developed with the involvement of CCG programme leads and shows the links between the delivery of the CCG's strategy and the delivery of the Health and Wellbeing Strategy

Fin**ancial Impact**

The below table shows the CCG's planned expenditure for 2014/15 and 2015/16. These figures have been adjusted to show the impact of the QIPP schemes as outlined above. In summary the CCG is on course to deliver its planned 2% surplus in both years of the operating plan.

	Year 1: 2014-15	**Year 2: 2015-16**
EXPENDITURE	**£000's**	**£000's**
Acute Contracts	**162,001**	**162,449**
Prescribing	**31,073**	**32,567**
Primary Care	**13,574**	**13,332**
Mental Health Contracts	**40,111**	**42,143**
Community Health Contracts	**50,759**	**50,976**
Continuing Care Contracts	**14,564**	**14,909**
Other Commissioning	**3,624**	**3,627**
Corporate Running Costs	**6,795**	**6,258**
Other Corporate Costs	**3,678**	**3,595**
Contingency and Reserves - 0.5% Contingency	**1,738**	**1,771**
Contingency and Reserves - Non-Recurrent Reserve	**8,226**	**3,346**
Contingency and Reserves - Better Care Fund	**1,800**	**8,438**
Contingency and Reserves - Transitional Payments	**0**	**0**
Contingency and Reserves - Readmissions	**0**	**0**
Contingency and Reserves - Risk Pool Contribution	**2,000**	**2,000**
Contingency and Reserves - Local Investment	**0**	**0**
Contingency and Reserves - Other	**1,000**	**2,000**
Contingency and Reserves - Return of Previous Year's Surplus (Deficit)	**0**	**0**
TOTAL EXPENDITURE	**340,943**	**347,411**
SURPLUS \ (DEFICIT) CARRIED FWD	**6,715**	**6,823**
SURPLUS REQUIREMENT	**6,953**	**7,085**
GAP	**(238)**	**(262)**

Next steps

The Transformation team will continue to:

- Develop savings plans to ensure we can realise maximum benefits
- Seek to reduce or manage projected investments
- Work with clinical leads and partners to develop further improvement schemes

Programme Management

Programme management for QIPP schemes will follow the standard CCG format as outlined in appendix 2. Each programme has a working group which is made up of a minimum of the Governing

Body Lead, CCG Transformation Team Lead, Clinical Lead and CSU support. In most cases this also includes representatives from providers such as Barts Health and ELFT. There is also strong representation from LBTH's Public Health team, and other LBTH officers. These working groups feed into the Transformation and Innovation Committee, a sub-committee of the Governing Body.

Appendices

Appendix 1: Tower Hamlets CCG QIPP Schemes

Programme	Summary	Key Outcomes	Investment (£000s)	Savings (£000s)
Maternity	- Continue to commission the MSLC - Continue to commission the Maternity Mates services - Continue to set challenging targets for Barts Health to improve quality of care and patient experience - Along-wide midwifery unit: Continue to put pressure on Barts Health to open a midwifery led unit on the 8th floor of the RLH hospital – as this will help with capacity at the site, and is also a 'place of birth setting' request by our local mothers. - Ensure women understand the range of choices that are available to them regarding place of birth; including the alongside unit, the Barkentine Centre and at home. - Develop new antenatal and postnatal pathways The CCG will work with members of the Barts Maternity Quality Board (NEL CCGs, Public Health and Barts Health) to ensure these pathways: - bring the antenatal pathway with national best practice - offer advice to patients around postnatal support that is comprehensive and tailored to our demographic; - help increase take-up of community support in the post-natal period; - foster a positive and on-going relationship with parents and their local child health services. - Increase information and education around how to access and use maternity services - Maternity & mental health pathway : Following a scope of current service provision in 1314, a decision will be made as to whether the CCG will refresh the pathway and develop services to meet any gaps in 1415. - Discharge: The CCG will ensure Barts Health reviews its systems for discharge to ensure women are sent home in a timely manner, based on nature of delivery, and with the right support systems in place. CQUINs to incentivise:	Improved Patient Experience	20	0

	- Better patient experience - Reduction in hospital-based births for low-risk women - Early access to support services - Continuity of care			
Children and Young People	The overarching aim of the programme is to commission safe, clinically effective and responsive services for children and young people, enabling them to achieve their full potential. The focus for 2014/15 will be on the following community health services: - Speech and language therapy (SALT) - Children's community nursing team (CCNT) - Occupational therapy - Physiotherapy - Specialist children's assessment and clinics (SCAC) - Continence In reviewing the above services, the objectives were to: - Develop robust specifications, - Take into consideration the impending changes to the Children's and Families Bill - Begin discussions with partners to foster a more collaborative approach to commissioning children's services Development in 2014/15 SALT: - Commission an early years speech and language therapy service in collaboration with the London Borough of Tower Hamlets (LBTH) - Fund additional postoperative input for children and young people with cochlear implants. - Fund 0.5 additional SALT input for the specialist dysphagia caseload. <u>Children's Community Nursing Team (CCNT)</u> - Commission a nurse to focus purely on training and education for non-health staff and providers.	SALT support for under 5s, resulting in improved outcomes later in life Timely and quality postoperative input for cochlear implants, dysphagia, and continence Improved patient/family/carer choice and satisfaction Greater collaborative working between occupational therapy and physiotherapy services Successful implementation of the SEND reforms Greater capacity within the LAC team to fulfil the recommendations of an independent review and CQC audit	397	0

	- Fund a pilot project for CCNT to adopt a family partnership model with the continuing care caseload. <u>Occupational Therapy and Physiotherapy</u> - Develop a 'single therapies' specification, incorporating both occupational therapy and physiotherapy. <u>Specialist Children's Assessment and Clinics (SCAC)</u> - Fund a Designated Health Officer to work with the SCAC service to support them with readiness for the implementation of the SEND reforms in September 2014 - Fund Looked After Children Nurse and Admin Support <u>Continence</u> - Commission a community continence service to cover the full spectrum of need – low, moderate and high.	Timely and quality support for the Child Death Overview Panel (CDOP) Consistency in approach regarding transition, safeguarding and the management of cross border/out of borough patients		
Urgent Care	The vision of Tower Hamlets CCG is to ensure that people with urgent care needs receive a high quality service in the right place, first time. In redesigning the urgent care system, Tower Hamlets CCG is seeking to: - develop a clear, simple 24/7 model - ensure that patients are seen by the skill group best able to meet their needs - ensure that primary care needs are addressed by an individual's own practice whenever possible - ensure that A&E and ambulance services concentrate their skills on the more serious and life threatening conditions - educate and inform local people about the range of services available to them, and how to make the most appropriate choices - develop a cost effective model which maximises benefits for patients In 2014/15 we will: - Introduce paediatric streaming to the urgent care centre	Reduction in A&E attendances Improve patient experience Improve A&E performance	0	46

	- Conduct a review of the walk in centres - Conduct a review of the GP Out of Hours (OOH) service - Support the ongoing implementation of 111 - Develop and deliver of patient education/social marketing initiatives			
Achieving Excellence in Primary Care	Strategy: 1. To create and nurture an environment of leadership and innovation for General Practice to deliver patient centred care. 2. To secure the role of the General Practice teams as the expert generalists in the wider healthcare system, who works with other providers to integrate services for patients. 3. To address the unprecedented levels of demand for General Practice services, supporting Practices to meet patient needs. 4. To ensure that General Practice in Tower Hamlets is supported by strong infrastructure to allow it to develop, grow and deliver high quality, equitable services for patients. 5. To maximise what we can achieve through working collaboratively across Practices and with local communities within the network arrangements. In 2014/15: - Training for GPs in solution-focused approaches, to support people in building better relationships with patients. - Development opportunities in mindfulness, as a way of improving the health of clinicians as well as patients. - Develop the GP intranet site to support General Practice.	Strong leadership for General Practice, with a structure and process for building leadership for the future Greater and more effective collaboration across providers, reduced administrative burden and improved patient experience across the pathway Practices who are able to flex adequately to meet the needs of their population, with an improved patient experience Healthy and resilient Practice teams, a sustainable future workforce and adequate resourcing for General Practice	564	150

	- Provide support to Practice to enable them to come together to plan how they might develop "Micro-teams". - Establishing a leadership programme across the General Practice workforce in Tower Hamlets. - Establishing an innovation fund for General Practice in Tower Hamlets to support change and testing new ways of working.	Create equity in clinical and patient experience indicators, greater dissemination and uptake of Best Practice across networks and strong community engagement		
Prescribing	Three themes 1. Quality Investment - New business cases include – two nutrition related programmes building on work we are already doing – quality improvement and procurement opportunity scoping – one new project around asthma – Existing CSPs around specials and Scriptswitch – Innovative on-going quality medicines optimisation solutions rendered through – Joint Prescribing and Formulary work manage entry of new drugs – NIS work	Reduction in prescribing costs Improved prescribing practice Improved clinical outcomes	1634	2662
Community Health Services	Tower Hamlets Vision for Community Health Services: - Engaging with our communities - Preventing hospital admissions - Coordinating Services In 2014/15: - Improve CHS productivity. E.g. reduce DNA rates - Develop high quality service and performance information - Market testing for provision of Wheelchair Services, GP Out of Hours and Adult and Children's continence services -	Improved productivity Improvements to the quality of services and patient experiences	466	700
Planned	Over the next 3 years our vision is to provide safe, patient-centred, cost-effective	Management of referrals	120	3649

Care	and integrated planned care services that meet the needs of the local population. We need to improve patient care and to manage growing care needs within the current financial budget. This initiative aims to: • Improve outpatient activity efficiency at Barts. This includes establishing clinically informed thresholds for C2C and N:FU ratios that are adhered to contractually • Re-design and develop improved pathways where intelligence suggests there is scope for better patient care and efficiency savings. • Encourage and support practices to reduce variation and improve the quality of GP referrals to secondary care Develop stronger links between primary and secondary care In 2014/15 we will focus on the following specific projects: - Improving productivity at our main providers - Introcuce Calprotectin Testing in primary care - Tele-dermatology Pilot - CAS vfm project - Improve the dermatology paediatric pathway - Improve Gynaecology/ Fertility pathways - Review Anticoagulation services - Community/ Secondary care Optometry review	to hospital (stable or decreasing) Improved patient experience Shorter waiting times		
Mental Health	Our Mental Health Strategy sets out our vision for improving outcomes for people with mental health problems in Tower Hamlets. It sets out how, over the next five years, we will work together to promote mental health and well-being in our communities, prevent Tower Hamlets residents from developing more significant mental health problems, and ensure that when people do need them, mental health services are of the highest possible quality, proactively supporting people to recover. It demonstrates our ambition to deliver against the National Outcomes Framework for Mental Health contained in No Health Without Mental Health.	Fewer people will experience stigma and discrimination People will feel that mental health services treat them with dignity and respect, and inspire	1146	1140

	Our vision is built around the three pillars, of building resilience in our population, ensuring high quality treatment and support, and supporting people to live well with a mental health problem. The foundations of the Strategy lie in the shared values that underpin a whole person approach and the principle that mental health is everybody's business. The overarching principle that governs the Strategy is that it takes a lifecourse approach, actively considering how the whole population can be supported to be mentally healthy from cradle to grave. We believe that in delivering the commitments that we will detail in this Strategy, we will measurably improve outcomes for people with mental health problems and their carers. Key actions for the delivery of the Strategy over the 2014-15 year include: • We will develop a public mental health and well-being programme which will include a portfolio of evidence based public mental health interventions, which will identify how we will deliver this, alongside other public mental health commitments over 2014/16 • We will map current services available to support maternal and infant mental health in order to identify gaps, improve access for groups at higher risk, improve coordination across services and develop proposals to strengthen the universal tier of the service (including Maternity services, Health Visiting and services delivered from Children's Centres, primary care and by voluntary and community organisations) • We will ensure that the roles of school nurses in relation to emotional health and well-being are clearly articulated in specifications for the reprocurement of the School Health service • We will develop a refreshed service model for child and adolescent mental health services. A project board will be set up across all stakeholders to oversee this work including the development of a set of service specifications to deliver the refreshed service model. This will include	hope and confidence Mental health awareness across our communities, will improve People will receive a diagnosis and appropriate support as early as possible People will be able to make choices about their care Families and carers will feel more supported People will be able to access timely crisis resolution, close to home People will have access to support to find employment, training or education People will experience smooth transitions between services At risk communities will have access to targeted preventative support		

	consideration of the impact of potential changes to the CAMHS service model to services for adults of working age. We will develop a refreshed model for the delivery of day opportunity and support services, with an accompanying procurement plan • We will continue the work to remodel and recommission resettlement and rehabilitation team pathways • We will review talking therapies providers, and develop a commissioning plan for future talking therapies pathways • We will develop a refreshed service and activity model for the primary care mental health service (including social care) • We will re-procure tobacco cessation and obesity services to explicitly include access for people with a serious mental illness • We will review the model for in-patient care of older adults with a functional mental health problem • We will develop a specification for mental health support in the community health service locality teams (within the Integrated Care Programme) • We will review community mental health services for older adults in the context of our work to develop integrated care • We will commission more dementia cafes • We will develop a new web resource summarising information on mental health services in the borough for service users and professionals • We will develop a rolling programme of training for GP's and other primary care staff.			

Long Term Conditions	Over the course of the next two years we plan to continue using the existing working arrangements whilst in parallel developing a more strategic approach across all LTCs. We will work with our CCG colleagues and partner organisations to develop a strategy which identifies and addresses the overarching needs of all people with LTCs. The strategy will aim to ensure that services supporting LTCs are provided in a high quality and cost effective way for all Tower Hamlet's residents. The ideas and experiences of service users will be central in commissioning services designed around their needs. We will undertake a review to rationalise existing services that are already providing patient education and self-management to ensure they are effective in empowering people with long term conditions to take care of themselves. A Long Term Conditions Board will be convened to develop the strategy for 2015/16, with representation from Local Authority, Barts Health, Public Health, CCG LTC Board Lead and Clinical Leads, Integrated Care Programme leads, mental health representatives, as well as key voluntary sector providers. Planned initiatives for 2014/15 The following projects will be delivered through the existing Working Group arrangements. Details on individual projects can be found in the attached supporting documents: 1. Development of a tool for case finding and optimising the management of heart failure 2. Securing funding for Consultant Cardiologist input into the CVD care package MDT 3. Developing a email/telephone based support service for epilepsy 4. Undertaking a needs assessment for specialist Home Oxygen Service (HOS) in Tower Hamlets 5. Supporting the pharmacy asthma project 6. Implementing Asthma UK Clinical Guidelines for the management of asthma 7. Developing a smoking cessation metric as part of the COPD care package	Improvement in clinical indicators Reduction in A&E attends and emergency admissions	100	177

	8. Non-recurrent funding to continue the Diabetes Lunch club developed by WHFS to facilitate self management, lifestyle change and education amongst Bangladeshi's with diabetes 9. Coordinated review of diabetes services with a view to commissioning a complementary set of services reflecting the needs of the community 10. Undertake a review of liver disease services			
Integrated Care	Tower Hamlet CCG aims to ensure patients with complex long term health and social care needs and their carers experience seamless and co-ordinated care. The CCG has signed up to the "National Voices Work" definition and heard patients call for *"care that is planned with people who work together to understand me and my carer(s), put me in control and co-ordinate and deliver services to achieve my best outcome"* In 2013/14 the CCG approved the following: - Resources to expand rapid response to extend the service from 8am – 8pm and for integrated community team and 8 care navigators - Mental Health Liaison Services - Enhanced primary care offer (Coordinated care NIS) In 2014/15 the CCG will: - Expand the target population in primary care: The scope of the integrated care programme will expand to cover all patients identified in the top 5%. - Invest in self care and self management to help improve the health of those lower down the 'risk pyramid' - Invest in thorough evaluation and organisational development of the programmes	Reduction in use of emergency services Reduce duplication of services Improve the patient and carers experience of service delivery Promotion of independence through support for self-care Improved clinical outcomes Improved communication	1382	4924
Cancer	- Strategy in development. - Cancer working group first meeting in March 2014 Main focal points: - Develop a shared understanding of commissioning roles and	Improved cancer performance Earlier detection	0	0

	responsibilities - Early detection and prevention - 2WW referral system forms - Input/involvement into BLT Cancer Strategy planning - Review of urgent diagnostics availability - TH GP Cancer educational needs met	Patients exercising greater choice		
Last Years of Life	Incentivising SJH and SPC team work together to educate clinicians across Barts CAGs . SJH and SPC teams work with hospital teams to educate them on providing the very best standard of care for those/need to die in hospital The audit of all deaths in hospital against quality and experience metrics and all bereaved carers offered the option of taking part in the VOICE survey. Consolidation of Integrated Care programme/ Co-ordinated Care Network Improved Service Continue to work with local WELC partners across health and social care, CVS and patient groups, to support those caring for people in the last years of life	Reduction length of stay / hospital deaths and subsequent associated costs Improved quality/experience of care More patients receiving a hospice standard of care, More patients having their wishes and preferences met (dying in a place of death that is familiar and comfortable, medicines withdrawal etc.) More equitable care, as a greater range of people (diagnosis, age, ethnicity) will access good quality LYOL care	0	0

Other Schemes	- InHealth contract reduction - Protected Learning Time - recurrent budget - HIV Testing in Acute Setting		134	106

Appendix 2: CCG QIPP Governance

Governance of QIPP Plans

Each QIPP area is developed through a working group model, supported by:

- A CCG Clinical Board Member
- A CCG Clinical Lead for the given area
- A member of the CCG's management team
- CSU and Public Health support as required
- Provider representatives

Each QIPP area is required to hold a programme plan and submit regular progress updates and exception reports to the appropriate board or subcommittee (see below)

Working groups are given the devolved responsibility to develop strategies and change programmes. These are then signed off by the CCG board.

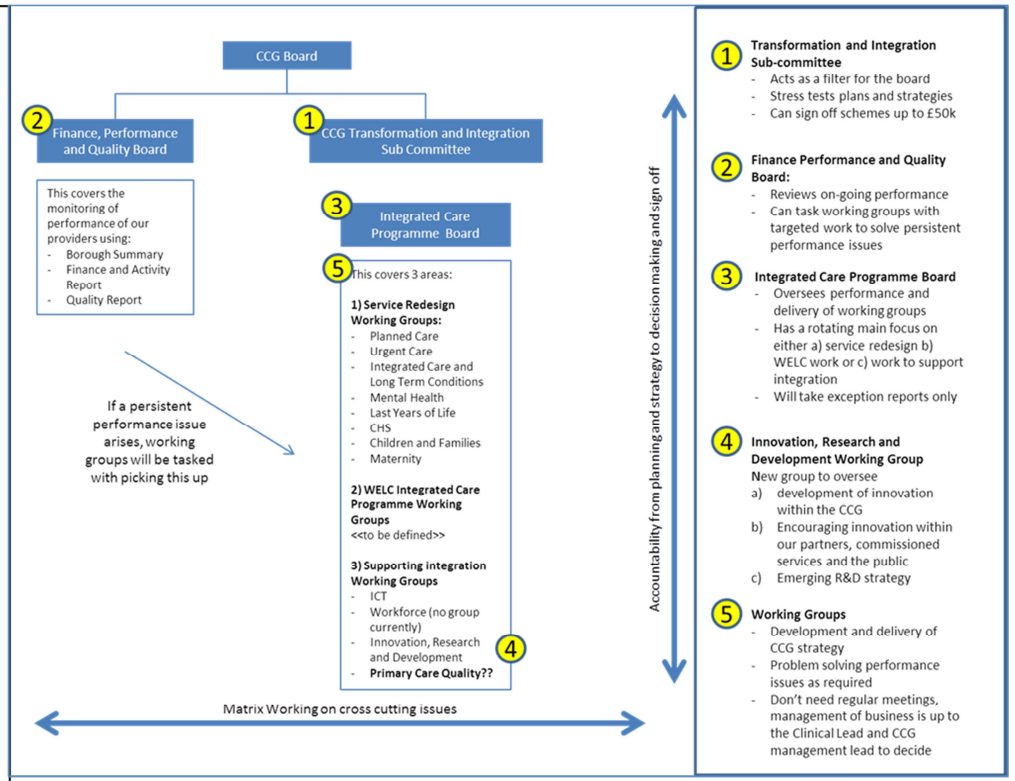
Working groups are then expected to manage the delivery of these strategies and when needed, account for any non-delivery or other issues through the exception reporting and escalation process.

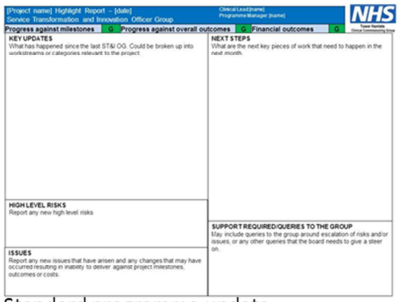
Risks

Any significant risks will be incorporated into the Board Assurance Framework and be regularly monitoring by the CCG board.

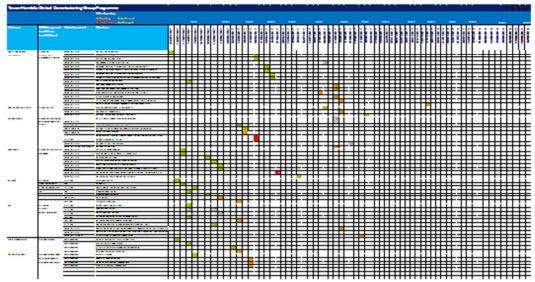
Poor Performance

Working groups are also required to take leadership on any performance issues in their area. For example, if there were persistent issues regarding A&E performance then the Urgent and Emergency Care Working Group would be asked to utilise their existing clinical relationships to identify mitigating actions. Where appropriate these will also be incorporated into developing strategy.





Standard programme update



Standard project plans

Health and Wellbeing Board 24th March 2014	
Report of the London Borough of Tower Hamlets	**Classification:** Unrestricted
Health and housing workshop feedback	

Lead Officer	Robert McCulloch-Graham
Contact Officers	Louise Russell
Executive Key Decision?	No

Executive Summary

On Tuesday 4th February a Joint workshop between the Health and Wellbeing Board and the Tower Hamlets Housing Forum (THHF) in recognition of housing's role as wider determinant of health. The workshop focused on the four priority areas outlined in the Health and Wellbeing Strategy: maternity and early years; healthy lives, mental health and long term condition and cancer. A list of actions developed has been developed with further discussion on delivery taking place in THHF's executive meeting.

Recommendations:

The Health and Wellbeing Board is recommended to:

1. To note the contents of this paper.

1. REASONS FOR THE DECISIONS

1.1 N/A

2. ALTERNATIVE OPTIONS

2.1 N/A

3. DETAILS OF REPORT

3.1 The notes of the Joint health and housing workshop held on Tuesday 4th February are contained in this paper. A list of joint health and housing actions focusing on the four priority areas of the Health and Wellbeing Strategy have been drawn up and will been taken to THHF executive.

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1. There are no financial implications of this report.

5. LEGALCOMMENTS

5.1. Consideration of the interaction between Health and Housing is consistent with the general policy, reflected in the Health and Social Care Act 2012, of giving HWBs responsibility for joint health and wellbeing strategies. The Statutory Guidance on Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies published on 26 March 2013 sets out that the HWB will need to consider wider social, environmental and economic factors that impact on health and wellbeing such as housing when preparing the joint strategic needs assessment.

5.2. Consequently, the recommendation to note the attached report falls within the HWB's Terms of Reference, in particular to identify needs across Tower Hamlets and publish and refresh the Joint Strategic Needs Assessment so that future commissioning/policy decisions are based on evidence.

5.3. There are no immediate legal implications arising from this report.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1. Housing is highlighted as a wider determinant of health in the Health and Wellbeing Strategy, which aims to improve the wellbeing of all Tower Hamlets residents.

7. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

7.1 N/A

8. RISK MANAGEMENT IMPLICATIONS

8.1. N/A

9. CRIME AND DISORDER REDUCTION IMPLICATIONS

9.1 N/A

10. EFFICIENCY STATEMENT

10.1 N/A

Appendices and Background Documents

Appendices

- None

Background Documents

If your report is a decision making report, please list any background documents not already in the public domain including officer contact information.

- None

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Joint health and housing workshop notes

Tuesday 4th February 2014 15.30 – 17.00

Attendees:

Tom Maher	Circle Housing
Dr Lucja Kolkieqicz	ELFT
Mags Groves	ELFT
Darren Summers	Family Mosaic
Kate Simpson	Family Mosaic
David Amery	Housing Link
Sharon Hanooman	HWBB/THCVS Vice Chair/Women's Health and Family Services
Martin Ling	LBTH D&R
Deborah Cohen	LBTH ESCW
Leo Nicholas	LBTH ESCW
Robert Driver	LBTH ESCW
Charlotte Saini	LBTH ESCW
Carrie Kilpatrick	LBTH ESCW
Tim Madelin	LBTH Public Health
Luise Dawson	LBTH Public Health
Mary Kneafsey	PRHA
Thufayel Islam	Social Action for Health
Sandra Fawcett	Swan Housing
Myra Garrett	Tenants and Residents Forum
Mike Tyrrell	THCH
Allyson Matthews	THH
John Wardell	Tower Hamlets CCG

Opening address –*Louise Russell (LBTH's Service Head for Corporate Strategy and Equality)*

- Housing is a recognised as a wider determinant of health in Tower Hamlets' Joint Health and Wellbeing Strategy
- Health Wellbeing Board (HWBB) and Tower Hamlets Housing Forumhave set up this workshop to develop actions around the four priority areas of work from the Health and Wellbeing Strategy
    - Maternity and early years
    - Mental health
    - Healthy lives
    - Long term conditions and cancer

Health begins at home – A look at integrating health services within Housing – *Kate Simpson (Health and Wellbeing Project Manager) and Darren Summers (Director of New Business)*

In 2012 Family Mosaic launched "Health, Wealth and Wellbeing", their manifesto for change through housing. They are currently undertaking a project to assess the way in which housing interventions can help reduce costs in the NHS, for example through working with health services to provide home based treatment or promoting general health and wellbeing initiatives to their tenants and helping with self-management.

Note of Workshop

1. Mind Mapping- Post-it note session

The workshop was split into four groups each looking at one of the respective Joint Health and Wellbeing Strategy priorities. Individual actions were placed on post it notes and grouped into a few core themes.

Maternity and early years	Children's services Multi agency partnerships Decent Homes Self-help/support
Mental health	Community Development Financial Inclusion Strategic Planning Tenancy Management Training and provision of services Property services
Healthy lives	Use of common facilities Work with residents and the voluntary and community services (VCS) Better multi-agency working Communication channels Needs assessments and mapping
Long term conditions and cancer	Tenant and resident social inclusion Integrated health, social care and housing services Assistive technology (AT)

2. Action Planning – Development of actions and prioritising

Using the themes from the mapping exercise, a list of actions were developed alongside the identification of leads and development of a timeline.

Maternity and early Years

Proposed Action	**Who leads?**	**Who is involved?**	**When does it start?**	**When does it finish?**
Promote the energy co-op/brokerage service. Need refreshed comms plan around this, including promotion through professionals working in children's services who would go into homes, such as health visitors. The co-op could also be promoted through the council's parenting network and parent advice centre, as well as in GP surgeries, children's centres, nurseries and schools, youth clubs, housing providers and landlords, as well as raising staff awareness moregenerally.	Alan Warner (attendee at the workshop) (LBTH) and the Energy team. However Alan and team will be dependent on strong working with partners to enable the wide reaching comms plan to work.	Children's Centres, Maternity Mates, Health Visitors, Schools, youth clubs, GP Surgeries, clinics, Landlords, Housing Providers, Children's Vol sector, Parenting Network leads and Parents Advice Centre.	An initial meeting to be set up with Poplar Harca and Alan. This could then be reported to THHF. A meeting with children's should also be organised to get input and support as to which partners in children's to approach.	This would be a 12 month project- once comms are refreshed and plan written will be rolled out and numbers tracked.
Increase local children's services professionals' awareness of what is a safe home	Housing providers to provide and disseminate materials	Maternity Mates, Health Visitors, Registered Providers	2014/15	Ongoing

Mental health

Proposed Action	Who leads?	Who is involved?	When does it start?	When does it finish?
A borough wide compact on dealing with tenants with poor mental health. Compact to include registered providers, the Council and mental health services. As part of the development of the compact, a protocol on supporting vulnerable tenants should be developed and shared by RPs.	LBTH Strategic Housing in partnership with THHF exec.	Registered Providers (RPs); mental health services; LBTH Strategic Housing; THHF Exec.	This is to be included in the THHF workstream with facilitation by LBTH's Strategic Housing team	Ongoing piece of work as the compact will continue to develop as the needs of tenants change.
Training programme on Mental Health Awareness (standardised) for housing staff as part of a broader health and wellbeing training programme.	ELFT, VCS such as Mind in Tower Hamlets or Rethink	Registered Providers (RPs); THHF Exec	2014/15	Ongoing
Develop a case forum for RPs to discuss MH cases in an anonymous way and to share best practice	THHF exec	Registered providers; LBTH ESCW (providing professional guidance)	2014/15	Ongoing
Work with Family Mosaic on their "Health begins at home" pilot. With the sharing of the pilot's evaluation (once published).	THHF exec; Family Mosaic	THHF exec; LBTH; mental health services Tower Hamlets CCG; RPs	2014/15	

Healthy lives

Proposed Action	Who leads?	Who is involved?	When does it start?	When does it finish?
Energy efficiency as integral part of Decent Homes programme	THHF Asset Management Group	RPs	Next meeting of the Asset Management Group	Ongoing
Map out who's doing what already - in Tower Hamlets and wider. Best practice should be promoted to and disseminated to relevant organisations	THHF Communication Involvement Network Group; Health Wellbeing forum of Council for Voluntary Services (CVS)	RPs; TRAs and community groups; lunch clubs; VCS organisations; 'Can Do' grant recipients.	Immediate	September/October 2014
Pilot identifying vulnerable tenants together with GPs on particular areas/estates	Tower Hamlets CCG/THH	Integrated Care Board External advice on information governance	2014/15	
Pilot of a resident led assessment of barriers to healthy lives and what needs to change	Poplar Harca Community Ward Forums	TRAs; schools; public health; local community groups; health centres/GP surgeries	2014/15	

Long Term conditions and cancer

Proposed Action	Who leads?	Who is involved?	When does it start?	When does it finish?
Better partnership approach to making older people aware of assistive technology (AT)	LBTH ESCW – AT strategy	THHF exec; THCCG; VCS organisations; Health and social care providers	April 2014	Ongoing
Focus on high risk tenants and the sharing of health/care information with housing providers. Additionally the involvement of tenants in their support planning	THCCG THHF Exec	THCCG; LBTH ESCW; THHF Exec; RPs; Health and social care providers	2014/15	Ongoing
Tackling social isolation; with the development of a borough wide strategy.	HWBB	HWBB; THHF Exec;	2014/15	

3. Next Steps

Presentation of the notes and actions to THHF Exec
Development of a delivery plan

Health and Wellbeing Board 7.3.2014	Tower Hamlets Health and Wellbeing Board
Report of: Tower Hamlets CCG	**Classification:** Unrestricted
Transforming services, changing lives in east London	

Contact	Jane Milligan, Chief Officer Tower Hamlets CCG

Executive Summary

Local CCGs (Waltham Forest CCG, Tower Hamlets CCG, Newham CCG, Barking and Dagenham CCG, and Redbridge CCG), NHS England, Barts Health and other local providers have established a clinical transformation programme called Transforming Health, Changing Lives in east London, which will bring together the existing CCG Integrated Care Programmes with a new 'sister "Improving Hospital Care" work-stream.

The work, which was launched in February 2014 and is expected to run until July 2014, willdevelop a baseline assessment of the drivers for change in the local health economy and support further discussions about the scope, scale and pace of change. Key outputs from this work are:

- a detailed 'case for change', delivered through a clinically led, comprehensive clinical engagement process

- establishing the appropriate foundations for a longer term joint transformation programme should partner organisations conclude that this is necessary in order to bring forward whole system, health economy-wide improvements in the clinical and financial viability of local services in east London.

The launch of the programme has been broadly welcomed.

Recommendations:

The Health and Wellbeing Board is recommended to:

1. note the date of the case for change stakeholder event (4 April)
2. consider a suitable date for a discussion on the HWBB agenda regarding the case for change.

1. Introduction

The NHS in east London faces the very real challenge of providing care for a growing local population, whilst continuing to meet the health needs of some of the most deprived areas seen anywhere in the UK.Providing for today while planning for a tomorrow which is unlikely to see budgets rising to the same extent as demand, will require us to think differently about how we provide care, and make changes to where and how care is provided if we are to meet the growing needs of local people.

Local CCGs (Tower Hamlets CCG, Newham CCG, Barking and Dagenham CCG, Waltham Forest CCG, and Redbridge CCG), NHS England, Barts Health and other local providers have established a clinical transformation programme called*Transforming Health, Changing Lives* in east London, which would bring together the existing CCG Integrated Care Programmes with a new 'sister "Improving Hospital Care" work-stream.

The work, which was launched in February 2014 and is expected to run until July 2014, will develop a baseline assessment of the drivers for change in the local health economy and support further discussions. Key outputs from this first phase of work are:

- a detailed 'case for change', delivered through a clinically led, comprehensive clinical engagement process

- establishingthe appropriate foundations for a longer term joint transformation programme should partner organisations conclude that this is necessary in order to bring forward whole system, health economy-wide improvements in the clinical and financial viability of local services in east London.

Tower Hamlets CCG, together with the other partnership organisations will be engaging with key stakeholders such as local councils, Health and Well Being Boards and other local providers to develop and test ideas.

Once completed, the case for change will be shared widely and subject to far reaching engagement, preferably with an accompanying scope and plans for any further work.

Governance and engagement

The governance arrangements for the programme have been established and include:

- a Programme Board as a key element of the structure – tasked with providing the strategic oversight for the Programme. To reflect the external decision making requirements, the Programme Board reports to the relevant statutory bodies of CCGs, providers and the NHS England.

- aClinical Reference Group and clinical working groups reflecting the key clinical leadership role in exploring and shaping a 'Case for Change'.

- a communications and engagement work stream that recognises the importance of engaging local stakeholders in our work at an early stage. Whilst the programme is expected to coordinate this work, CCGs will lead local engagement with Health and Wellbeing Boards and Healthwatch – primarily through existing governance links. Programme members have met with Healthwatch representatives to discuss this approach and how they would like to participate. We have agreed that we will facilitate Healthwatch to produce a report from the public/patient perspective.

The intention is to invite other key stakeholders such as local authorities to become involved through a number of workshops – the first of which is on 4 April.

Clinical engagement
Invitations have recently been sent to participating CCGs, Barts Health and the Homerton Hospital inviting nominations forclinicians and other front line staff to join clinical working groups. Community and mental health service providers and the London Ambulance service are also being asked to nominate representatives and we are establishing links with academic partners. The clinical working groups will focus on:

- Unplanned Care (urgent and emergency care, acute medicine, non-elective surgery)
- Planned care (long-term conditions)
- Clinical support services
- Planned care (surgery)
- Paediatrics
- Maternity and neonatal care.

GPs, CCG and Barts Health staff have been informed to provide them with an understanding of the work and to enable them to engage with the nominated clinicians – so that the programme can elicit views from a much broader body of health professionals than those directly associated with the groups.

Case for change

Local clinicians will use their own knowledge of national and international best practice to review current health and social care services. This work will be written up in a 'Case for Change', anticipated to be published in July 2014. The case for change will:

- review the key drivers for change for example population projections, recommended best practice and existing capacity constraints
- identify the key challenges that will need to be addressed over the next decade and also the scope, scale and pace of change required
- considerwhy, and in what specialties, local clinicians think change is needed to ensure we can provide the very best care for local residents.

The case for change will not set out recommendations for change.

Working in partnership, and pooling our resources to look at what is best for our patients will ensure we have a joined up approach that crosses geographical and organisational boundaries.

Why have we taken this step?

The five CCGs have a duty to promote a comprehensive health service for their population of around 1.3 million people. Barts Health is the largest NHS Trust in England. The Trust has a turnover of £1.2billion and a workforce of 15,000, so the Trust's contribution to the local economy is vital to the population of east London and the local economy.

Today, local NHS services face the very real challenge of providing care for a rapidly growing local population, whilst continuing to meet the health needs of some of the most deprived areas seen anywhere in the UK.

The health economy is never static. Change is happening all around the system. In the last year, since the establishment of CCGs, we have seen the introduction of NHS 111, the development of integrated care and soon the launch of personal health budgets. We need to

respond to these changes to ensure that benefits are realised and unintended consequences are avoided.

However, we also know that some services simply need to improve to meet local needs. We need to address the areas where we are not so good. We know that the quality of care we provide is inconsistent. We need to work better with providers and with social care to address the challenges we face and decide how we can introduce new and different ways of providing care.

Collectively commissioners have agreed with providers to look at the challenges we face, to ensure we can continue to provide the care our patients need, at the best possible place for them. We know in order to improve the health of our local population, that hospital trusts and commissioners can no longer work in silos. Organisation boundaries must not and cannot impede the commitment to deliver improvements at scale across the partnership.

We also need to make sure that any changesin the future happen safely and effectively.

In developing their case for change, clinicians will be guided by the principles of the Francis Report to ensure delivering first class care for patients and local populations is the driver for change.

The publication of Sir Bruce Keogh's review of urgent and emergency care proposed emergency care being delivered in two types of centres, both with the right care and expertise in place and with senior clinicians present 24/7. He described these as: Emergency Centres – capable of assessing and initiating treatment for all patients before transferring them where necessary and; Major Emergency Centres – much larger units providing a range of highly specialist services. Phase two of this review includes a delivery group responsible for reviewing and commenting upon the viability of the proposed clinical system and contributing to the detailed design of the new system and the tools and guidance. Local CCGs and providers will need to consider and respond to this review.

In addition to this national review, the publication of the Care Quality Commission's (CQC) investigation of Barts Health NHS Trust services in Jan 2014 included 15 compliance actions and said that staffing levels were variable; equipment wasn't always readily available; some parts of the hospital environment compromise patients' privacy and dignity (especially at Whipps Cross) and there were problems with patient flow, bed occupancy and discharge planning. The Trust is currently developing an action plan to address this and the Transforming services, changing lives programme will help inform this.

Our commitments

In order to guide clinicians in their discussions, and to provide reassurance to key stakeholders regarding the aims of the programme, the Transforming Services, Changing Lives partnershiphas agreed the following commitments to guide the work of the programme:

- The safety of our residents, people who work or visit the area, our patients and the quality of our care is our priority.
- We are working in partnership to develop services and ensure they are integrated as part of a broad system of care focused on each individual.
- Commissioners aim to commission the best quality care, drive better clinical outcomes for patients and improve the performance of our providers in an open, transparent and fully accountable way. We are improving the health of our community and reducing health inequalities by using our resources in the best possible way for patients.
- Providers are committed to providing excellent care for our local population, including specialist care to rival the best in the world.

- Emergency care will continue to be provided at The Royal London, Whipps Cross and Newham hospitals. We believe that all three hospitals should provide a safe haven for local residents – whatever their condition. We expect staff to be available 24 hours a day, seven days a week to provide care to seriously ill and injured patients, whether they need resuscitation, treatment or a rapid diagnosis and transfer to a centre with more specialist staff.

  However we know that existing emergency care can improve further, and we want to develop different ways of working that use the skills that we have to deliver better care. We will be carefully looking at the best models of emergency care, recognising the importance of local access and making sure we make the most of having a world class specialist centre at The Royal London.
- Women will continue to be able to have their babies at The Royal London, Newham, Whipps Cross, our birthing centres, or at home. We will continue to improve the care and experience offered to all mothers and their babies sharing best practice and expertise.
- By enhancing community and primary care services we anticipate that more care will be provided closer to people's homes and the need for hospital care will be reduced.
- We expect Barts Health to continue to develop it existing estate, including at Whipps Cross and Newham. This will ensure care is provided in more high-quality buildings that are safer and better for patients and will reduce our dependency on out-of-date facilities.
- To meet the continuously changing challenges to the NHS, clinicians might agree that some services should be changedto improve patient experience and clinical outcomes, and to ensure all services meet new quality standards. We will always take into account the views of local doctors and nurses, and those of our patients and communities.

Next Steps

1. We are inviting directors of public health, directors of social care, OSC chairs, HWBB chairs, Healthwatch chairs and local MPs to the event on 4 April (as well as clinicians, members of the partner organisations, associated organisations e.g. academic partners). The HWBB is asked to consider whether there are other invitees that we should consider.

2. We expect most members of the HWBB to be invited to contribute to the development of the case for change in some way or another going forward but we will also provide regular updates on progress to the HWBB as this work progresses. However the HWBB is asked to consider planning an agenda item at a future meeting to discuss the case for change.

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Health and Wellbeing Board 24 March 2014	Tower Hamlets Health and Wellbeing Board
Report of the London Borough of Tower Hamlets	**Classification:** Unrestricted
Memorandum of Understanding	

Lead Officer	Robert.McCulloch-Graham ESCW Corporate Director
Contact Officers	Deborah Cohen
Executive Key Decision?	No

Executive Summary

1. Prior to the formation of Barts Health NHS Trust, the London Borough of Tower Hamlets (LBTH), NHS East London and The City (subsequently Tower Hamlets Clinical Commissioning Group) and Barts Health entered into a memorandum of understanding (MOU) with respect to a number of health and social care factors to reduce health inequalities and improve the health of local people. The MOU also had a focus on providing employment opportunities for Tower Hamlets residents.

2. The MOU was a non-legally binding agreement and is expressed in terms of joint aspirations rather than as a detailed list of performance indicators or outcomes

3. This paper provides an update to the Health and Wellbeing Board on the actions undertaken to implement the MOU to date.

4. A copy of the full MOU is attached as Appendix 1.

Recommendations:

The Health and Wellbeing Board is recommended to:

1. The HWBB is requested to NOTE:

   - Progress made on the MOU (Appendix 2 and Appendix 3)
   - The ongoing work between LBTH and Barts Health NHS Trust around employment
   - The overlap between the MOU (especially paragraphs 7 and 8) and the

work on the BCF and integration and that the MOU may be a duplication of this area of the Board's work. This will be reflected in the update referred to below.

- That the MOU can be used as a way to maximise social value (in the sense of the Public Values (Social Value) Act 2012) and that officers will look at how to measure this more formally as a way of evaluating the success of the MOU.

2. HWBB is recommended to AGREE:

- That the MOU be reviewed in early 2014-15 and an update be taken to the Health and Wellbeing Board not later than July 2014 that reflects the above comments.

1. REASONS FOR THE DECISIONS

1.1 There is an overlap with the BCF and integration agenda in the borough; however ongoing work on employment needs to continue and undergo scrutiny by the HWBB.

2. ALTERNATIVE OPTIONS

2.1 The board is asked to note the report and agree that a review be held in 2014/15; the board may decide that this isn't the appropriate course of action.

3. DETAILS OF REPORT

The MOU covers the following areas:

MOU	Comments
1. Improve the health and healthcare of people who live, visit or work in the borough and in particular to reduce health inequalities.	Key role of Public Health who since the MOU have moved into the local authority. In addition there has been the appointment by BH of a director of public health and development of a range of activity.
2. Improve local access to services and information to local people about facilities so that they can choose and use	On going work programme of the HWB Board Engagement subgroup which is now well established between all parties to

the right facilities for them.	the MOU.
3. Agree a programme of health promotion work to be delivered through schools to reach all pupils, their families and the wider community and to work with schools to promote careers in the local NHS	The Healthy Lives team work with all schools in the Borough. Through the Healthy Schools Award, schools work to improve and maintain their provision around certain health based criteria including healthy eating, drug education, physical activity, emotional health and well being and sex and relationships education. At present 89% of schools in the Borough have achieved the award and most other schools are working towards it. In addition the Healthy Lives team also run the Advanced Healthy Schools programme where schools carry out two specific projects aimed at making measurable improvements to their pupils health. All schools have a fixed project around obesity and choose one more; recent examples have included improving packed lunch provision, projects on improving the school dining experience. A programme around Mental Health resilience is being commissioned for schools.
4. Work closely with our local university, Queen Mary, University of London to develop new opportunities for students within Tower Hamlets to enter in to medical training	Not progressed at this point.
5. Agree a mechanism that ensures efforts regarding economic development are aligned and encourage a) big businesses to relocate to the area b) small businesses to start up and develop in the	Ongoing meetings between key senior staff in BH and the Council.

borough	
6. Agree and implement a programme to encourage and assist at least 1,000 residents of Tower Hamlets over the next two years to apply for and obtain employment in the new Trust.	Overall, in terms of LBTH residents as a proportion of posts currently filled, BH has approximately 15% of staff from LBTH. Since the MOU was signed over 531 residents have been employed by the Trust which has pushed the total to over 2000. See Appendix 4 for Equality Breakdown. Development of Recruitment Plan between Skilsmatch and Barts Development of Barts Health Learning Hub.
7. Work with the Council to actively encourage local people to make their voice heard and ensure patient and public involvement is at the heart of every aspect of the new Trust.	See 2 above. Reports from Healthwatch are received at each HWB Board meeting It should be noted that engagement is a part of the BCF plan that was approved at the February HWB Board meeting.
8. Develop robust mechanisms to report to the Council on performance with particular respect to community health services and hospital discharge pathways.	The role of the HWB Board in this area is set out in the Better Care Fund plan and there will be a separate set of metrics that will be monitored. The BCF can be seen to supersede this part of the MOU.
9. Provide opportunities for council representation in the trust governance structure.	Delivery of this commitment (in para 9) is tied to BH becoming a foundation trust. The appointment of a Council advisor to BH has not been progressed in the context of the establishment of the HWB Board. However BH have met with the Council leadership many times over the last year and have put structures in place to engage local

	authority members in addition to working with Health Scrutiny (a statutory requirement), and sitting as co-opted members on the Health and Wellbeing Board.
10. Ensure that the Council is engaged in the development of high quality health services and provided with every opportunity to influence healthcare provision locally.	This is the fundamental objective of the Health and Wellbeing Board and the HWB Strategy. The performance of the Board is monitored by a performance framework attached to the Strategy.
11. Actively review the working arrangments and the success of collaborative working – in particular a programme of regular meetings between the Mayor and the Chief Executive of the Council, commissioners, and the Chair and the Chief Executive of the new trust.	As above - BH have met with the Council leadership many times over the last year and have put structures in place to engage local authority members in addition to working with Health Scrutiny (a statutory requirement), and sitting as co-opted members on the Health and Wellbeing Board.

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1. There are no financial implications arising from the recommendations in this report. The report is dealing with the ways of working outlined in the Memorandum of Understanding.

5. LEGALCOMMENTS

5.1. The recommendationsare consistent with the general policy, reflected in the Health and Social Care Act 2012, of giving HWBs responsibility for joint health and wellbeing strategies. As the HWB has statutory status, due regard should be given to its decision making authority within its terms of reference.

5.2. These recommendations are within the terms of reference of the HWB agreed by the Mayor in Cabinet on 4 December 2013, in particular to encourage integrated working between persons who arrange for the provision of any health or social services in Tower Hamlets for the advancement of the health and wellbeing of the people in Tower Hamlets.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1. The MOU is agreement to improve the health and healthcare of people who live in the Borough and reducing health inequalities across all the protected

characteristics as well improve employment opportunities for residents of Tower Hamlets.

7. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

7.1 N/A

8. RISK MANAGEMENT IMPLICATIONS

8.1. The MOU is a non-legally binding agreement and nothing in the MOU is intended to require the Council to act contrary to its legal duties.

9. CRIME AND DISORDER REDUCTION IMPLICATIONS

9.1 N/A

10. EFFICIENCY STATEMENT

10.1 N/A

Appendices and Background Documents

Appendices

- Appendix 1 - Memorandum of Understanding
- Appendix 2 - Barts Health Learning Hub Scoping Document
- Appendix 3 - Update from Barts Health on MOU
- Appendix 4 - Barts Health Employment Breakdown (Tower Hamlets Data)

Background Documents

If your report is a decision making report, please list any background documents not already in the public domain including officer contact information.

- None

Memorandum of Understanding between:

London Borough of Tower Hamlets; and

NHS North East London and the City; and

Barts Health NHS Trust, the new trust formed by the merger of Barts and The London NHS Trust, Whipps Cross University Hospital NHS Trust and Newham University Hospital NHS Trust

The parties agree to work collaboratively and proactively to:

1. improve the health and healthcare of people who live, visit or work in the borough, and in particular to reduce health inequalities;
2. improve local access to services and information to local people about facilities so that they can choose and use the right services for them;
3. agree a programme of health promotion work to be delivered through schools to reach all pupils, their families and the wider community; and to work with schools to promote careers in the local NHS;
4. work closely with our local university, Queen Mary, University of London to develop new opportunities for students within Tower Hamlets to enter into medical training;
5. agree a mechanism that ensures efforts regarding economic development are aligned and encourage:
    a. big businesses to relocate to the area
    b. small businesses to start up and to develop in the borough; and
6. agree and implement a programme, to our best endeavours, to encourage and assist at least 1,000 residents of Tower Hamlets over the next two years to apply for and obtain employment in the new Trust, for instance by:
    a. helping the long-term unemployed into training or jobs
    b. focusing on working with children and young people to develop their career opportunities
    c. helping talented local people to become graduates
    d. the trust seeking to use its influence with local training providers to make medical training more accessible to local people
    e. providing local people access to jobs
    f. notifying the Council Employment and Enterprise Team of all job opportunities arising with the Trust; and
    g. participating in the Council Employment and Enterprise initiatives

The NHS Trust will:

7. work with the Council to actively encourage local people to make their voice heard and ensure patient and public involvement is at the heart of every aspect of the new trust;
8. develop robust mechanisms to report to the Council on performance with particular respect to community health services and hospital discharge pathways. This may be incorporated into the NHS contracts from 2012/13 onwards and the new Trust will negotiate this with commissioners; and
9. provide opportunities for council representation in the trust governance structure including (subject to approval by Monitor) a nomination of at least one Governor to

the board of governors when the trust becomes a Foundation Trust and, in the meantime, the Council to propose an advisor to the Barts Health NHS Trust Board.

10. ensure that the Council is engaged in the development of high-quality health services and provided with every opportunity to influence healthcare provision for local people.

The parties agree to:

11. actively review the working arrangements and the success of collaborative working - in particular a programme of regular meetings between the Mayor and Chief Executive of the Council, commissioners, and the Chair and Chief Executive of the new trust.

This Memorandum sets out a statement of some of the intended benefits and deliverables to be derived from the joint working between the parties. The parties enter into this Memorandum in good faith.

The parties acknowledge that this is a non-legally binding agreement and nothing in this Memorandum is intended to require the parties to act contrary to their legal duties and obligations, nor to act contrary to the instructions of the Secretary of State for Health or Monitor. It is not intended to, and shall not be deemed to, establish any legal partnership between the parties, constitute either party as the agent of the other, nor authorise either of the parties to make or enter into any commitments for or on behalf of the other party.

The agreement shall remain valid until the time at which responsibility for commissioning services transfers from NHS North East London and the City to new Clinical Commissioning Groups.

To be signed and take effect from 1 April 2012.

Aman Dalvi

Chief Executive London Borough of Tower Hamlets

Peter Morris

Chief Executive Barts Health

Andrew Ridley

Managing Director NHS East London and City

APPENDIX 2

Barts Health Learning Hub

INTRODUCTION

1. East London is an area with high unemployment and low skills. Compared to a London average of 23% of adults being economically inactive, 29% of Tower Hamlets residents and are economically inactive. Correspondingly unemployment rates are higher in Tower Hamlets – 13% compared to the 9% London average[1]. The local population is relatively low skilled and less well qualified than the London and national averages. Despite some recent improvements, over 10,000 18-24 years olds are without work in East London. 50% of 19 year olds in Tower Hamlets do not have a Level 3 qualification, and local residents are significantly underrepresented in many areas of the Trust, especially clinical areas such as nursing.

2. The aim of the project is to create a Community Asset that will act as a gateway to members of the local community who want to work in the health and social care sector. The Barts Health Learning Hub would provide a learning resource for Tower Hamlets residents that would support them to be more employable in the sector. The programme that would be offered at the Hub would relate to skills and employment needs at Barts Health and the local health economy. Barts Health NHS Trust is a very large employer in the area and would provide an anchor employer in terms of progression to work. However, the intention would be to develop pathways to employment in other NHS Trusts, Primary Care and ultimately, to social care employers as well, in pursuit of integrated health and social care policy development.

LEARNING HUB PROGRAMME

3. The initial training programme would be taken from the Community Works for Health programme which offers an employment pathway to local residents and includes the following elements:

    - NHS Opportunity Days – Group assessment where residents are offered Information Advice and Guidance
    - Pre-employment training
    - Work Placements

[1] NOMIS March 2013 figures

Over 500 residents will be engaged through the programme in 2013/14 and an estimated 150 of these will obtain work at the Trust.
In addition, the CWfH pathway offers a route into apprenticeships, including clinical and non-clinical roles. A target of 150 apprentices has been set for 2013/14 and cohorts have started in HCA, Theatre, Estates and Facilities and a range of administrative and support areas.
A parallel programme would be established with the Trust's contractors for Facilities Management training which would incorporate pre-employment training, apprenticeship and skills development training for the main trades of staff who keep the infrastructure of the Trust going, including portering, catering, cleaning, security and sterile services.

ENHANCED PROGRAMME

4. A major review of careers pathways from apprenticeship level to Band 4 is currently underway and being delivered in partnership with Skills for Health. One product of this will be clearer careers pathways with defined gateways at each point. This will help direct priorities in terms of B1-4 training. Eligible existing staff are already able to benefit from the advanced apprenticeship programme.

5. The creation of a learning hub will create the capacity to improve the quality of the existing provision by providing dedicated space with up to date ICT and equipment. However and more importantly the Learning Hub will allow the scaling up of the programme and a widening of its scope.

6. Examples of new courses would include

- Work it Out (Support with functional and IT skills for potential staff who do not pass at Level 1)
- Similar support for existing staff, including contracted out staff with poor functional and IT skills
- In house apprenticeship training
- In house skills training to enable progression along skills pathways
- Assessor training
- Facilities Management centre of excellence programme

Table A provides an indication of the growth in numbers that could occur thought the project, and as noted, this would be matched by similar improvements in quality

Category of Learners*	Learner numbers before project [1]	Learner numbers after project [2]	Change in learner numbers = [2-1]
Adult Skills Classroom based	75	250	175
Apprenticeships	75	150	75
Existing staff	75	200	125
Total	**225**	**600**	**375**

* Examples of categories include, but are not limited to, Adult Skills Classroom Based, Adult (19+) Apprenticeships, Adult Skills Workplace, Higher Education and so on.

THE LEARNING HUB

The new facilities would include classroom, skills lab and interviewing rooms with a dedicated reception area. Based on a similar facility at University of Birmingham, around 500 sq. m. would be needed to include 2 x training rooms, 1 x skills lab, an IT learning suite and 3 x interview rooms. Alongside this will be required an open plan office and dedicated office for management. Unless provided nearby, male, female and accessible toilets will be needed along with a break out area where trainees can consume refreshments and work on assignments outside of formal training times. A small kitchen facility would also be required.

MANAGEMENT

The learning hub would be managed initially by staff associated with the Community Works for Health programme, especially the Health Careers Manager, the Community Programmes Manager, the Learning and Skills Coordinator and the Community Employment Coordinator, together with associated administrator. However the full business case for the Hub will set out the potential for increased revenue from external training and employment sources and the consequent use of additional training and employment staff. It is anticipated that this will be a partnership model and so there would be joint use of the facility with other training providers and community organisations. These partnerships, and the development of internal capacity, would lead to the full use of the Hub and its resources.

BUSINESS PLAN

This outline scope would form the basis for a full business plan that would develop option appraisal and economic assessment during November 2013.

APPENDIX 3

Progress update on implementing the Memorandum of Understanding between Barts Health NHS Trust, NHS North East London and The City and the London Borough of Tower Hamlets

1. Overview

Immediately prior to the formation of Barts Health NHS Trust, the London Borough of Tower Hamlets (LBTH), NHS East London and The City (subsequently Tower Hamlets Clinical Commissioning Group) and Barts Health entered into a memorandum of understanding with respect to a number of health and social care factors to reduce health inequalities and improve the health of local people.

2. Purpose

This paper provides an update from Barts Health NHS Trust to our partners on the actions undertaken by the Trust to implement the Memorandum of Understanding (MOU) in 2013.

3. Activity from Barts Health NHS Trust

3.1. Members of LBTH Overview and Scrutiny Committee and LBTH Health Scrutiny Commission toured The Royal London Hospital on 16 January, visiting the Emergency Department, urgent care service and the maternity unit

3.2. Our Trust Board receives a patient story at every meeting

3.3. Initial contacts made between the Tower Hamlets Healthwatch young people's panel and the Women and Children's Health Clinical Academic Group

3.4. We meet regularly with all local Healthwatches, including Healthwatch Tower Hamlets. We are looking to formalise these meetings into a Heathwatch reference group to look at topics such as patient experience, Turnaround and quality of care

3.5. LBTH was invited to take part in our smoking cessation consultation, which will help us implement plans to make all Barts Health sites a smoke free environment

3.6. Representatives from our sexual health, inclusion, membership and patient experience teams attended the Stepney Green Fair on 10 August

3.7. Representatives from our sexual health, diabetes, membership, patient experience and Emergency Department nursing leadership teams attended the Tower Hamlets Healthwatch launch

3.8. We are attending the Tower Hamlets Clinical Commissioning Group public engagement event on 19 October

3.9. Our Community Works for Health team have been shortlisted for the Health Service Journal Awards to be held in November under the workforce category. They were also highly commended last year

3.10. Our Community Works for Health team hosted a community awards event to acknowledge those who have gained/graduated from apprenticeship and training within Barts Health. Awards included the Star Award, Access to Practical Nursing Studies and Nursing Assistant Training

3.11. Barts Health has attended several events to engage with local schools and colleges. Our Public Health team led a group of healthcare professionals at Bishop Challenor School for “Inspire the Future”, an event attended by Nick Clegg and Joanna Lumley, where they provided careers advice to students from the school

3.12. Our Public Health team also attended the City of London Guildhall for a careers event sponsored by Hackney Education Business Partnership for students from Hackney schools, and organised two events at QMUL’s Centre of the Cell facility for students from Mulberry School and Bishop Challenor School, providing information about careers in the NHS. Over 100 students attended these events

3.13. The Access to Higher Education Practical Nursing Studies course came to end last year, with seven learners taking part. The course was a pilot qualification with a workbased element which allowed participants to attain the 60 credits which are required to secure a place on a nursing degree course. From the seven learners, three went to university to study nursing and two will be making an application in 2013

3.14. Barts Health attended the Osmani Trust health open day earlier in 2013 as part of our joint Tower Hamlets Weight Management Service

3.15. Barts Health's Keeping Healthy in Ramadan campaign Trust-wide focused on persuading people to keep hospital appointments during the Holy Month, while providing them with health information including how to continue to take medication even if fasting. The campaign involved leafleting community centres, pharmacies, mosques and GP surgeries across the Trust's patient population area and engaging local and BME media, who reported on the campaign and broadcast discussion items about it. Initial results indicate a drop in A&E attendance throughout the Ramadan period compared to last year

3.16. At its Annual Public Meeting on 18 September, the Trust heard a presentation from Community Links, a Newham-based organisation which supports community projects, and a local girls' school about a project to raise awareness of breast cancer and breast screening amongst ethnic minority communities. The project involved training a group of young people who could then educate students at the school. These students in turn were then able to brief their families. Survey information from Community Links suggests a considerable increase in awareness of breast screening amongst parents in the local area

3.17. The Jagonari Women's Centre director presented details of our local partnership at the Barts Health External Advisory Group

3.18. The Trust exhibited at the Bangladeshi Mental Health Awareness Day on 6 March

3.19. We organised a "Have a Go" event at the QMUL Centre of the Cell for Tower Hamlets Schools

3.20. We attended careers events at Central Foundation and Mulberry Schools

3.21. We are due to sign the Time to Change pledge on 10 October with other members of the LBTH Health and Wellbeing Board

3.22. We have joined the LBTH Apprenticeship Forum

3.23. We supported Mulberry School's successful application to establish a University Technical College (UTC) with Professor Jo Martin agreeing to join the Board of Governors

3.24. We participated in the East End Community Foundation event at State Street Bank, supporting local residents with employment advice

3.25. Our Community Works for Health team have achieved the following outcomes:

- 146 LBTH residents aged 18+ supported with employment advice and training, including work placements
- 44 local residents supported into employment, including 30 young unemployed people recruited into apprenticeship roles
- 13 more local residents already employed as Barts Health staff enrolled into apprenticeship training
- Over 100 Tower Hamlets school students supported with work experience and careers advice

3.26. However as the recruitment pipeline becomes clearer we expect to have up to 400 vacancies available that could be filled by employable candidates. With the appropriate support and resources from the Local Authority we believe that the we could together:

§ improve the supply of suitably trained job ready candidates from the Borough;

§ supply other parts of the health economy (e.g. GP Surgeries) with local candidates

§ Address local deficits in the health workforce (e.g. nurses from Bangladeshi backgrounds) though focused careers advice and promotion (e.g. building on the Nursing and Islam programme)

§ Develop a comprehensive health and employment programme that include addressing health barriers to employment such as poor mental health and muscular skeletal problems

§ Support good occupational health among local employers

3.27. We attended the Tower Hamlets Commission Fairness launch event on 30 September

3.28. We hosted a “patients in research” open day to promote the role of research at Barts Health NHS Trust and the importance to patients

3.29. Barts Health received the highly commended award in the Representative Workforce Category of the annual enei awards, promoting nursing careers in the Bangladeshi and Muslim community

30 September 2013

Barts Health NHS Trust

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Barts Health Tower Hamlets Residents and their Protected Characteristics
Current Staff in Post

	Permanent				Fixed Term Temp				Bank/Locum				
Age Group	**Bands 1-4**	**Bands 5+**	**Medical/Other**	**Total**	**Bands 1-4**	**Bands 5+**	**Medical/Other**	**Total**	**Bands 1-4**	**Bands 5+**	**Medical/Other**	**Total**	**Grand Total**
< 20	2			**2**	2		7	**9**			2	**2**	**13**
20 - 29	173	132	1	**306**	10	14	96	**120**		1	85	**86**	**512**
30 - 39	219	247	18	**484**	12	24	82	**118**		1	83	**84**	**686**
40 - 49	113	204	36	**353**	6	9	10	**25**			51	**51**	**429**
50 - 59	102	134	13	**249**	2	2	3	**7**			22	**22**	**278**
60 +	44	22	4	**70**	1		4	**5**	1		9	**10**	**85**
Grand Total	**653**	**739**	**72**	**1464**	**33**	**49**	**202**	**284**	**1**	**2**	**252**	**255**	**2003**

	Permanent				Fixed Term Temp				Bank/Locum				
Disability	**Bands 1-4**	**Band 5+**	**Medical/Other**	**Total**	**Bands 1-4**	**Band 5+**	**Medical/Other**	**Total**	**Bands 1-4**	**Band 5+**	**Medical/Other**	**Total**	**Grand Total**
No	383	472	37	**892**	28	40	155	**223**		2	221	**223**	**1338**
Not Declared	20	23	5	**48**			7	**7**			12	**12**	**67**
Undefined	236	234	29	**499**	5	8	37	**50**	1		17	**18**	**567**
Yes	14	10	1	**25**		1	3	**4**			2	**2**	**31**
Grand Total	**653**	**739**	**72**	**1464**	**33**	**49**	**202**	**284**	**1**	**2**	**252**	**255**	**2003**

	Permanent				Fixed Term Temp				Bank/Locum				
Ethnicity	**Bands 1-4**	**Bands 5+**	**Medical/Other**	**Total**	**Bands 1-4**	**Bands 5+**	**Medical/Other**	**Total**	**Bands 1-4**	**Bands 5+**	**Medical/Other**	**Total**	**Grand Total**
White	215	332	50	**597**	5	23	94	**122**	1	2	75	**78**	**797**
Mixed	15	16	0	**31**	2	1	7	**10**			3	**3**	**44**
Asian	289	149	17	**455**	16	6	46	**68**			75	**75**	**598**
Black	92	137	2	**231**	6	10	6	**22**			48	**48**	**301**
Other	21	90	1	**112**	1	9	4	**14**			10	**10**	**136**
Not Stated/Undefined	21	15	2	**38**	3	0	45	**48**			41	**41**	**127**
Grand Total	**653**	**739**	**72**	**1464**	**33**	**49**	**202**	**284**	**1**	**2**	**252**	**255**	**2003**

	Permanent				Fixed Term Temp				Bank/Locum				
Gender	**Bands 1-4**	**Bands 5+**	**Medical/Other**	**Total**	**Bands 1-4**	**Bands 5+**	**Medical/Other**	**Total**	**Bands 1-4**	**Bands 5+**	**Medical/Other**	**Total**	**Grand Total**
Female	503	569	39	**1111**	20	43	105	**168**	1	2	169	**172**	**1451**
Male	150	170	33	**353**	13	6	97	**116**			83	**83**	**552**
Grand Total	**653**	**739**	**72**	**1464**	**33**	**49**	**202**	**284**	**1**	**2**	**252**	**255**	**2003**

	Permanent				Fixed Term Temp				Bank/Locum				
Religion	**Bands 1-4**	**Bands 5+**	**Medical/Other**	**Total**	**Bands 1-4**	**Bands 5+**	**Medical/Other**	**Total**	**Bands 1-4**	**Bands 5+**	**Medical/Other**	**Bank Total**	**Grand Total**
Atheism	13	40	2	**55**	2	4	18	**24**		2	6	**8**	**87**
Buddhism	2	5		**7**			2	**2**			2	**2**	**11**
Christianity	132	222	11	**365**	8	30	27	**65**			41	**41**	**471**
Hinduism	2	8	2	**12**			9	**9**			4	**4**	**25**
I do not wish to disclose my religion/belief	62	94	11	**167**	2	2	77	**81**			64	**64**	**312**
Islam	180	92	4	**276**	15	3	21	**39**			49	**49**	**364**
Other	6	23		**29**	1	2	8	**11**			11	**11**	**51**
Undefined	256	255	42	**553**	5	8	40	**53**	1		75	**76**	**682**
Grand Total	**653**	**739**	**72**	**1464**	**33**	**49**	**202**	**284**	**1**	**2**	**252**	**255**	**2003**

	Permanent				Fixed Term Temp				Bank/Locum				
Sexual Orientation	**Bands 1-4**	**Bands 5+**	**Medical/Other**	**Total**	**Bands 1-4**	**Bands 5+**	**Medical/Other**	**Total**	**Bands 1-4**	**Bands 5+**	**Medical/Other**	**Total**	**Grand Total**
Bisexual	3	1		**4**							1	**1**	**5**
Gay	7	16	1	**24**		2	3	**5**			3	**3**	**32**
Heterosexual	313	348	18	**679**	24	36	91	**151**		2	117	**119**	**949**
I do not wish to disclose my sexual orientation	76	115	11	**202**	5	3	69	**77**			53	**53**	**332**
Lesbian		2		**2**							2	**2**	**4**
Undefined	254	257	42	**553**	4	8	39	**51**	1		76	**77**	**681**
Grand Total	**653**	**739**	**72**	**1464**	**33**	**49**	**202**	**284**	**1**	**2**	**252**	**255**	**2003**

Barts Health Tower Hamlets Residents and their Protected Characteristics
Current Staff in Post - Started Since April 2012

	Permanent				Fixed Term Temp				Bank/Locum		
Age Group	**Bands 1-4**	**Bands 5+**	**Medical/Other**	**Total**	**Bands 1-4**	**Bands 5+**	**Medical/Other**	**Total**	**Medical/Other**	**Total**	**Grand Total**
< 20	2	0	0	**2**	2	0	7	**9**	2	**2**	**13**
20 - 29	39	63	0	**102**	8	7	92	**107**	51	**51**	**260**
30 - 39	18	37	8	**63**	4	6	61	**71**	37	**37**	**171**
40 - 49	6	11	2	**19**	1	2	4	**7**	20	**20**	**46**
50 - 59	8	6	1	**15**	1	0	1	**2**	8	**8**	**25**
60+	7	0	0	**7**	0	0	4	**4**	5	**5**	**16**
Grand Total	**80**	**117**	**11**	**208**	**16**	**15**	**169**	**200**	**123**	**123**	**531**

	Permanent				Fixed Term Temp				Bank/Locum		
Disability	**Bands 1-4**	**Bands 5+**	**Medical/Other**	**Total**	**Bands 1-4**	**Bands 5+**	**Medical/Other**	**Total**	**Medical/Other**	**Total**	**Grand Total**
No	77	111	9	**197**	15	14	135	**164**	117	**117**	**478**
Not Declared / Undefined	2	4	1	**7**	1	0	31	**32**	5	**5**	**44**
Yes	1	2	1	**4**	0	1	3	**4**	1	**1**	**9**
Grand Total	**80**	**117**	**11**	**208**	**16**	**15**	**169**	**200**	**123**	**123**	**531**

	Permanent				Fixed Term Temp				Bank/Locum		
Ethnicity	**Bands 1-4**	**Bands 5+**	**Medical/Other**	**Total**	**Bands 1-4**	**Bands 5+**	**Medical/Other**	**Total**	**Medical/Other**	**Total**	**Grand Total**
White	19	66	8	**93**	3	10	78	**91**	36	**36**	**220**
Mixed	2	2	0	**4**	0	0	5	**5**	2	**2**	**11**
Asian	41	18	1	**60**	10	3	42	**55**	43	**43**	**158**
Black	11	19	1	**31**	3	2	3	**8**	19	**19**	**58**
Other	2	4	0	**6**	0	0	1	**1**	4	**4**	**11**
Not Stated/Undefined	5	8	1	**14**	0	0	40	**40**	19	**19**	**73**
Grand Total	**80**	**117**	**11**	**208**	**16**	**15**	**169**	**200**	**123**	**123**	**531**

	Permanent				Fixed Term Temp				Bank/Locum		
Gender	**Bands 1-4**	**Bands 5+**	**Medical/Other**	**Total**	**Bands 1-4**	**Bands 5+**	**Medical/Other**	**Total**	**Medical/Other**	**Total**	**Grand Total**
Female	50	88	5	**143**	9	13	89	**111**	77	**77**	**331**
Male	30	29	6	**65**	7	2	80	**89**	46	**46**	**200**
Grand Total	**80**	**117**	**11**	**208**	**16**	**15**	**169**	**200**	**123**	**123**	**531**

	Permanent				Fixed Term Temp				Bank/Locum		
Religion	**Bands 1-4**	**Bands 5+**	**Medical/Other**	**Total**	**Bands 1-4**	**Bands 5+**	**Medical/Other**	**Total**	**Medical/Other**	**Total**	**Grand Total**
Atheism	1	11	1	**13**	2	3	17	**22**	3	**3**	**38**
Buddhism	0	1	0	**1**	0	0	2	**2**	1	**1**	**4**
Christianity	21	46	4	**71**	3	7	25	**35**	26	**26**	**132**
Hinduism	0	1	0	**1**	0	0	8	**8**	3	**3**	**12**
I do not wish to disclose my religion/belief	16	31	4	**51**	1	1	71	**73**	50	**50**	**174**
Islam	37	20	2	**59**	10	3	19	**32**	31	**31**	**122**
Other	2	6	0	**8**	0	1	8	**9**	7	**7**	**24**
Undefined	3	1	0	**4**	0	0	19	**19**	2	**2**	**25**
Grand Total	**80**	**117**	**11**	**208**	**16**	**15**	**169**	**200**	**123**	**123**	**531**

	Permanent				Fixed Term Temp				Bank/Locum		
Sexual Orientation	**Bands 1-4**	**Bands 5+**	**Medical/Other**	**Total**	**Bands 1-4**	**Bands 5+**	**Medical/Other**	**Total**	**Medical/Other**	**Total**	**Grand Total**
Bisexual	1	0	0	**1**	0	0	0		0		**1**
Gay	2	4	0	**6**	0	1	3	**4**	3	**3**	**13**
Heterosexual	58	82	6	**146**	14	14	88	**116**	82	**82**	**344**
I do not wish to disclose my sexual orientation	16	28	5	**49**	2	0	60	**62**	35	**35**	**146**
Lesbian	0	2	0	**2**	0	0	0		1	**1**	**3**
Undefined	3	1	0	**4**	0	0	18	**18**	2	**2**	**24**
Grand Total	**80**	**117**	**11**	**208**	**16**	**15**	**169**	**200**	**123**	**123**	**531**

Health and Wellbeing Board 24th March 2014	Tower Hamlets Health and Wellbeing Board
Report of the London Borough of Tower Hamlets	**Classification:** Unrestricted
Oral Health of Children	

Lead Officer	Robert McCulloch-Graham
Contact Officers	Somen Banerjee
Executive Key Decision?	No

Executive Summary

This briefing paper gives an overview of the oral health of children in Tower Hamlets. It provides a background and basis for the targets in the Health and Wellbeing Strategy.

In Tower Hamlets 45.9% of 5 year old children have experienced tooth decay compared to 32.9% for London and 27.9% for England. Compared to 2008 oral health has improved nationally but deteriorated in Tower Hamlets.The percentage of children accessing dental services has increased from a baseline of 46.9% in 2006 when the current dental contact was introduced to the current figure of 53.4%. This compares to 62.9% for London and 69.1% for England.

Recommendations:

The Health and Wellbeing Board is recommended to:

1. Promote the Council's engagement with NHS England to increase the capacity within general dental practice including the resolution of issues delaying the opening of the new dental practice at the Harford Health Centre.

2. HWBB to note importance of oral health improvement programmes for children including the school fluoride varnish programme in addressing trends in dental decay

3. Explore the possibility of including figures from the dental school primary care service in monitoring the dental access indicator.

1. REASONS FOR THE DECISIONS

1.1 The improvement of oral health in children is outlined in the Health and Wellbeing Strategy under the Maternity and Early Years priority workstream.

2. ALTERNATIVE OPTIONS

2.1 HWB has the option of not following the Paper's recommendations.

3. DETAILS OF REPORT

3.1 A briefing paper giving an overview of the oral health of children in Tower Hamlets. It provides a background and basis for the targets as laid out in the Health and Wellbeing Strategy

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1. The Oral Health Improvement Programme for Children currently costs £150,000 and is funded from the Public Health Grant. 80% of this funding is for the Healthy Teeth in Schools Programme, a fluoride varnish programme to prevent tooth decay in children aged 3-6 years. Currently over 90% of nursery schools are participating in the programme.

4.2. Other public costs of dental service provision would generally be met via the CCG.

5. LEGALCOMMENTS

5.1. This report is pursuant to the Council'snew duties under Regulation 17 of the NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations 2012 to secure the provision of oral health promotion programmes and surveys

5.2. Therecommendations arising from this briefing paper arealso consistent with the general policy, reflected in the Health and Social Care Act 2012, of giving HWBs responsibility for joint health and wellbeing strategies and the joint strategic needs assessment, and fall within the functions of the HWB set out in its Terms of Reference.

5.3. The recommendation for the Council to engage with NHS England to increase the capacity within general dental practice Centre, falls within the HWB functions of encouraging integration and supporting partnerships under section 75 of the NHS Act 2006.

5.4. The second recommendation to note the importance of the oral health improvement programmes for children including the school fluoride varnish

programme falls within the function to identify needs and priorities across Tower Hamlets.

5.5. The final recommendation to explore the possibility of including figures from the dental school primary care service in monitoring the dental access indicator falls within the HWB function to have oversight of the qualityand performance mechanisms operated by member organisations.

5.6. When planning for integration of health and social care functions, the Council and its committees must have due regard to the need to eliminate unlawful conduct under the Equality Act 2010, the need to advance equality of opportunity and the need to foster good relations between persons who share a protected characteristic and those who don't. Some form of equality analysis will be required and officers will have to decide how extensive this should be.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1. [Report authors should identify any equalities or diversity implications and how the proposals contribute to the achievement of One Tower Hamlets. Please refer to the relevant section of the report writing guide when completing this paragraph.]

7. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

7.1 N/A

8. RISK MANAGEMENT IMPLICATIONS

8.1. [Authors should identify how the proposals in the report mitigate any risk to the Council and/or any risks arising from the proposals themselves and the action taken to address these.]

9. CRIME AND DISORDER REDUCTION IMPLICATIONS

9.1 N/A

10. EFFICIENCY STATEMENT

10.1 [Reports concerned with proposed expenditure, reviewing or changing service delivery or the use or resources must incorporate an Efficiency Statement. Please refer to the relevant section of the report writing guide.]

Appendices and Background Documents

Appendices

- NONE

Background Documents

- NONE

Paper on the Oral Health of Children for the HWBB

1 Introduction

1.1 This briefing paper gives an overview of the oral health of children in Tower Hamlets. It provides a background and basis for the targets in the Health and Wellbeing Strategy.

1.2 The latest figures on oral health and dental service uptake were derived from the national survey of 5 year old children carried out in 2012 and access figures for 2013 published by the Health and Social Care Information Centre.

1.3 Local Authorities have new statutory responsibilities (The NHS Bodies and Local Authorities (Partnership Arrangements, Care Trusts, Public Health and Local Healthwatch) Regulations, Part 4) specifically relating to oral health improvement.

1.4 The responsibilities include assessing the oral health needs of their population, developing oral health strategies, commissioning appropriate population-based oral health improvement programmes to meet those needs and commissioning oral health surveys as part of the national dental epidemiology programme or other local surveys.

1.5 Local Authorities are also responsible for delivering the PH Outcomes Framework Indicator 4.2 '*Tooth decay in children aged 5'*. The national dental epidemiology programme will provide the data for monitoring this indicator.

1.6 All clinical dental services for Tower Hamlets are commissioned by NHS England.

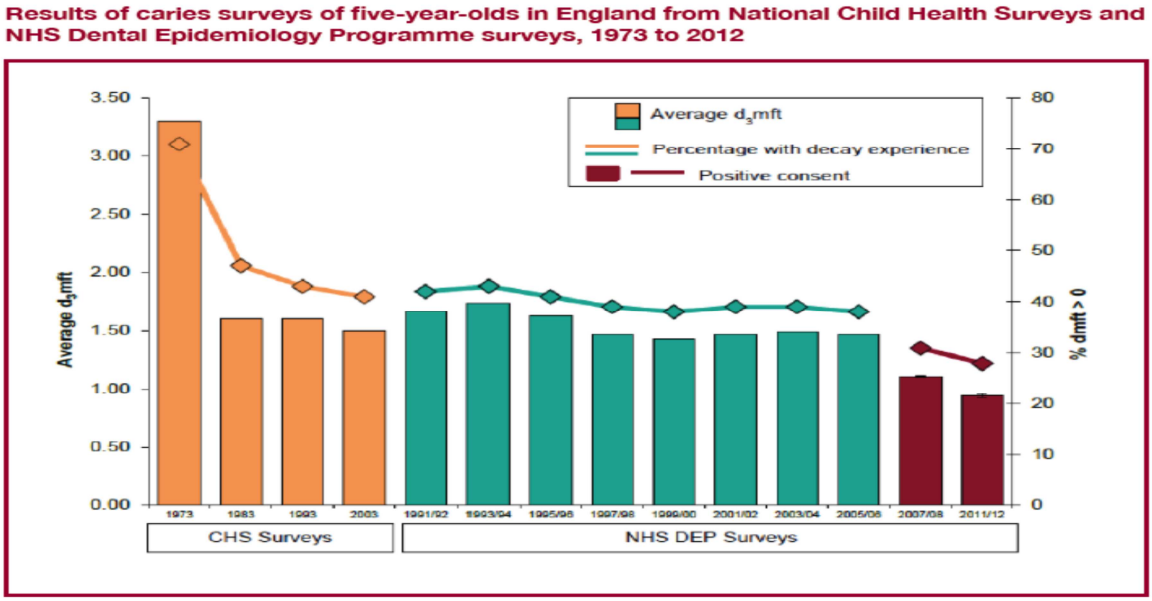
2. National picture

2.1 Nationally, there have been significant improvements of the oral health of children over the past 30 years. The latest survey shows reducing levels of dental disease with the exception of London (Figure 1).

2.2 National averages mask significant inequalities with the most deprived LAs having the highest decay levels

2.2 Improvements are thought to be due to increasing use of fluoride products, dental public health programmes and a focus on prevention in general practice

Figure 1. Oral health of 5 year old children in England 1973- 2012

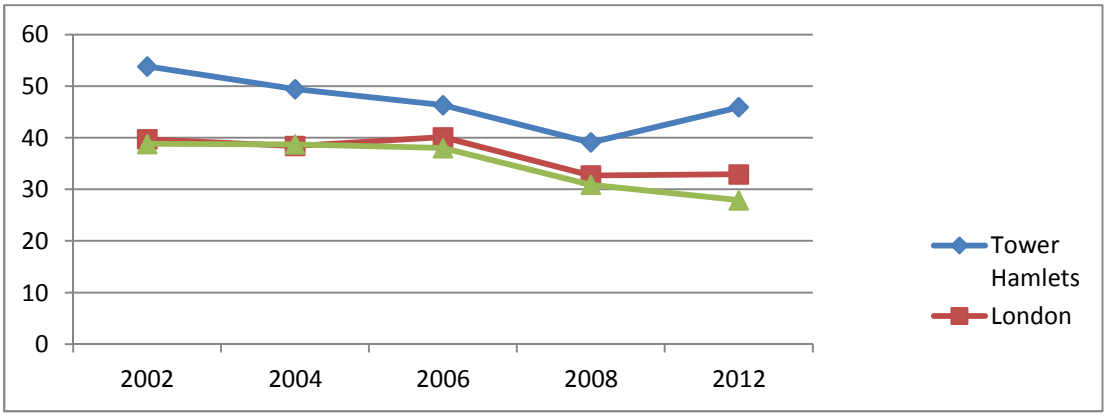


dmft: average number of teeth either decayed, missing (removed due to decay) or filled

3. Dental decay in Tower Hamlets

3.1 In Tower Hamlets 45.9% of 5 year old children have experienced tooth decay compared to 32.9% for London and 27.9% for England. Compared to 2008 oral health has improved nationally but deteriorated in Tower Hamlets (Figure 2).

Figure 2. Proportion of 5 year old children with decay experience



3.2 The average number of teeth affected by decay has remained the same at 1.78 when compared to the 2008 survey. Therefore whilst the

prevalence of tooth decay has increased the severity has stayed the same.

3.3 Dental abscess is a marker of significant decay or neglect. In Tower Hamlets, 1.7% of children have abscesses, similar to the figure for England. This is less than the figure for London of 2.2%. Compared to 2008 with a figure of 3.6% in Tower Hamlets there was a significant reduction in the proportion of children with abscesses.

4. Dental Access

4.1 Figure 3 summarises the trends in dental access for children from 2006 to 2013. The proportion of children accessing dental services has increased from a baseline of 46.9% in 2006 when the current dental contact was introduced to the current figure of 53.4% (2013). This compares to 62.9% for London and 69.1% for England.

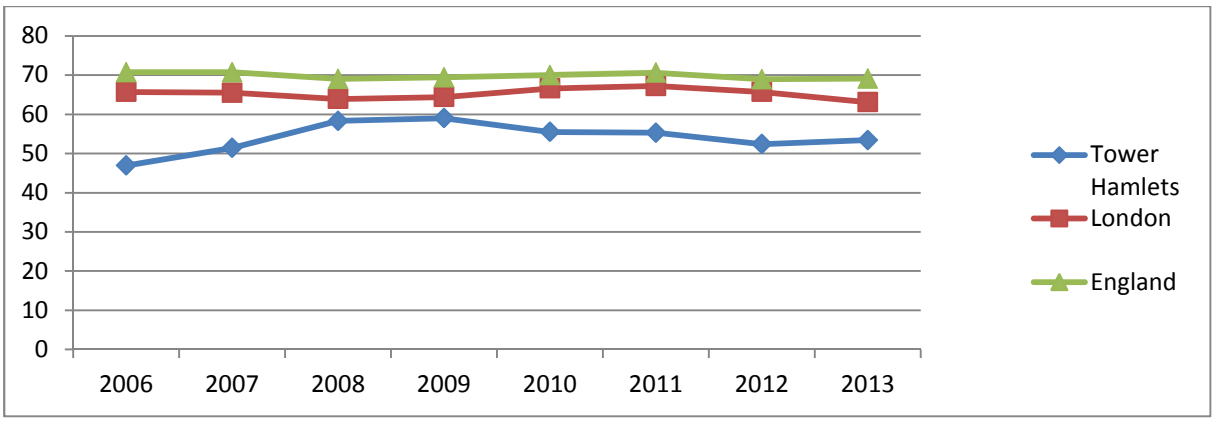
4.2 The steady increase from 2006 to 2009 is associated with a significant investment in dental services.

4.3 Fewer children in Tower Hamlets are accessing dental services compared to London and England.

4.4 Whilst the proportion of children accessing dental services in London and England has decreased the proportion accessing dental services in Tower Hamlets has increased.

4.5 A number of children access primary care dental services at the Dental Institute of Queen Mary University. The figures are not included in the national data. The proportion of children accessing dental services in Tower Hamlets is therefore thought to be much higher than the current figure of 53.4%.

Figure 3. Proportion of children accessing dental services 2006 - 2013



5 National and Local Action

5.1 A National Commissioning Better Oral Health Steering Group is working on evidence based guidelines for local authorities to support them in their new role. The group is expected to report in January 2014.

5.2 NICE is working on guidelines for local authorities to improve oral health of vulnerable groups.

5.3 The Council is implementing a number of programmes targeted at children. These include the Smiling Start, Brushing for Life and School Fluoride Varnish Programmes.

5.4 In order to deliver oral health improvements and the PH Outcome Indicator it is essential that these programmes continue to be supported and funded.

6. Dental Targets in the HWBB Strategy

	Target	Actual
Percentage of 5 year old children experiencing tooth decay	30%	45.9%
Percentage of children accessing dental services	62.9%	53.4%

7. Recommendations

7.1 Council to engage with NHS England to increase the capacity within general dental practice including the resolution of issues delaying the opening of the new dental practice at the Harford Health Centre.

7.2 Maintain the funding for the oral health improvement programmes for children including the school fluoride varnish programme.

7.3 Explore the possibility of including figures from the dental school primary care service in monitoring the dental access indicator.

Desmond Wright
Consultant in Dental Public Health
March 2014

Health and Wellbeing Board 24th March 2014	Tower Hamlets Health and Wellbeing Board
Report of the London Borough of Tower Hamlets	**Classification:** Unrestricted
Reform of Special Educational Needs (SEN): The Children and Families Bill 2013 & the Draft SEN Code of Practice	

Lead Officer	Robert.McCulloch-Graham ESCW Corporate Director
Contact Officers	David Carroll SEN & Inclusion Lead Principal Educational Psychologist
Executive Key Decision?	No

Executive Summary

This report outlines the changes required in practice and development of new systems because of the reform to Special Educational Needs legislation. The project board overseeing the change programme is consulting with key stakeholders from health education social care the voluntary sector and in particular parents at each stage of development.

There are three distinctive area of development that LA parent representatives and its partners are undertaking.

1. Agreeing Joint Commissioning Arrangements with the CCG through a work plan that looks at integrated commissioning.

2. Defining designing and promoting the Local Offer in partnership in particular with parent representatives

3. Transforming the way services are delivered so that parents' experiences are qualitatively different and specialist teams across all agencies and schools deliver assessments and interventions through the SEN system which is person centred and outcomes focussed.

Recommendations:

The Health and Wellbeing Board is recommended to:

1. Support the work of the project board and the plans to ensure that the Local Offer is underpinned by local authority and clinical commissioning group agreeing on local provision in line with the priorities of this Health & Wellbeing

Board.

2. Support the implementation of the SEN Reforms by promoting the greater responsibilities on non-education services to participate.

3. Support the Joint Commissioning Plans between the Council and the CCG to secure and review the wide range of provision made across all agencies to meet the needs of children and young people with SEN.

1. REASONS FOR THE DECISIONS

1.1 The new statutory SEN framework which come into force in September 2014 includes a duty on local Health and Well Being Boards to have oversight of arrangements to implement changes.

2. ALTERNATIVE OPTIONS

2.1

3. DETAILS OF REPORT

3.1 The scope of the Bill
The Bill covers a wide range of areas listed below; however the vast majority of the Bill's clauses refer to SEN changes and developments:

- Adoption
- Family Justice
- SEN
- Childminder Agencies
- Children's Commissioner
- Statutory Rights to Leave & Pay
- Time off Work
- Rights to request Flexible Working

3.2 This paper sets out to provide the board with:

- An outline of the key SEN changes to be introduced by the Children and Families Bill, the new SEN code of Practice and the timescales for introducing phased changes
- A broad outline of key areas for development that the LA is making in partnership with other stakeholders
- An assessment of what might be the implications for the LA as it implements changes
- A set of recommendations showing how the stage of developments might be taken forward

3.3 What's different to the present SEN system?
The approach; the child or young person is at the centre of the assessment of need and the Single Plan. All professionals working together carry out their role in a way which reflects the learning and culture of person planning approaches. Parents and carers have an active partnership role in identifying, developing and evaluating the support plan. Parents can have an increased choice through access to a personal budget. There is transparency and openness in regard to all parts of the process. Plans are outcome focussed with clear and accountable resource allocations.

3.4 To implement this different way of working and relating to children young people (CYP) and their families it will require a change in culture and behaviour of staff both within the Local Authority and amongst key partners especially in health. They will need to relate differently to services users, sharing power and information with them. Staff will need to develop and use new skills to engage with families so that the Single Plan is owned by the service user.

3.5 The Transformation Journey
In March 2011 the Government published its Green Paper Support and Aspiration - A new approach to special educational needs and disability which set out a vision for children with SEN. The principles outlined in the Green Paper have been reiterated with every subsequent publication.

3.6 In September 2011, 31 LAs combined with their local PCTs to work together on 20 SEN Pathfinder projects funded by the DFE. There common objectives have been to deliver a new system that adheres to the Green Paper's vision.

3.7 These projects were originally expected to finish in April 2013 and provide direction for future legislation. All projects have been extended until August 2014 with 10 selected as Champions to support developments with other LAs. The SEN Champions programme will now extend into 2015.

3.8 September 2012 draft legislation on reform of provision for children and young people with SEN was published. It confirmed the intention for changes in seven key areas;

- Streamlined assessment process, which integrates education, health and care services, and involves children and young people and their parents.
- New 0-25 Education, Health and Care Plan, replacing Statements and Learning Difficulty Assessments, which reflects the child or young person's aspirations for the future, as well as current needs.
- New requirement for LA, health and care services to commission services jointly re meeting the needs of CYP with SEN & disabilities.
- LAs to publish a clear, transparent 'local offer' of services for all CYP with additional needs, so parents can understand what is available.
- New statutory protections for young people aged 16-25 in FE and a stronger focus on preparing for adulthood.
- Offer of a personal budget for families and young people with a Plan, extending choice and control over their support.

- Academies, Free Schools, Further Education and Sixth Form colleges to have the same SEN duties as maintained schools

3.9 December 2012 Education Select Committee published its report 'Education Committee - Sixth Report Pre-legislative scrutiny: Special Educational Needs.' Most prominent of the committees conclusions were that the forthcoming regulations commit Health providers to specific timetables when conducting SEN assessments and that responsibilities for Health and Local Authorities in providing certain therapy services are substantially clarified. They also called for all current protections afforded by a Statement of SEN to be maintained in the new legislation and for a more coherent means of appeal/redress for parents dealing with a variety of agencies in Health and Education.

3.10 Early 2013 the revised Bill was introduced into Parliament. In October the DFE published its consultation documents on a draft for the new 0 to 25 SEN Code of Practice which will become statutory guidance from September 2014. They also consulted on associated draft regulations. The consultation closed 9th December 2013. The timetable for the next stages is in spring 2014 the Bill will receive Royal Assent (subject to Parliamentary process) and in September 2014 the reforms go live.

3.11 The main elements of the draft SEN Code of Practice
The draft Code has seven chapters some of which build upon the present arrangements and practice albeit with the expectation of changes in how the process is delivered and experienced by families and introducing new responsibilities and requirements. The definitions are clear this will be a statutory process including Education/Health/Care assessments but child must be shown to firstly have Special Educational Needs. The definition of SEN remains exactly as in the current Code of Practice. It defines disability as when a child or person has a physical or mental impairment which has a substantial and long term adverse effect on their ability to carry out normal day to day activities. So a child may be disabled and not have SEN, a child may have SEN and not be disabled and a child with significant care needs (requiring high levels of intervention) may or may not have SEN.

3.12 The new system
The Code sets out how the new systems must have children & young people to be at the heart of the system. There must be close co-operation between all of the services that support children & families. The system must be built on the early identification of children and young people with SEN. It must be clear & easy to understand and include Local Offers of education, health & social care services. For the most complex needs, a co-ordinated assessment and 0-25 EHC Plan will be necessary. The EHC Plan must have a clear focus on outcomes anticipating the support the child or young person may need for a clear pathway through education to adulthood, paid employment and independent living. The system must increase choice, opportunity & control for parents and young people and the offer of a personal budget for those with an EHC plan.

3.13 Parental Involvement

The Code expects parents children and young people to be more actively engaged in both the system and how assessments and decisions take place that affect them. Local Authorities will be given some additional duties and expected to redesign if necessary their systems so that parental engagement is at the heart of how SEN delivers services.

3.14 Some of the specific ways in which Local Authorities must ensure parental involvements have already been identified these include:

- Planning and reviewing the Local Offer
- Reviewing special educational and social care provision
- Drawing up individual EHC plans, in reviews and reassessments
- Person centred approaches adopted universally
- Tailoring support and personal budgets around the person's plan

3.15 The Local Offer

The SEN Bill and Code introduce a new concept of the Local Offer. Local authorities must publish, in one place, information about provision they expect to be available in their area for children and young people from 0-25 who have SEN. The Local Offer must be underpinned by local authorities and clinical commissioning groups agreeing on local provision & the priorities of the local Health & Wellbeing boards. Children, young people & families should be involved by local authorities in:

- Planning the content
- Deciding how to publish the local offer
- Providing feedback on services in the local offer

The Local Offer should have 2 key purposes:

1. To provide clear, comprehensive information about support and opportunities available

2. To make provision more responsive to local needs and aspirations by directly involving children & YP with SEN and parents & carers in its development

The Local Offer should be constructed so that it is engaging, accessible, transparent and comprehensive. It must include:

- Education, health and care provision for children & YP with SEN,
- Arrangements for identifying and assessing children & YP with SEN.
- Other education provision (outside schools & colleges)
- Training provision including apprenticeships
- Arrangements for travel to and from schools, post 16 provision and early years providers
- Support for children and young people moving between phases
- Supported preparation for adulthood including preparation for employment, independent living & community participation

- Information, advice & support from the LA about support for families with children with SEN
- Information about making complaints and being supported in conflict resolution

3.16 Settings Early Years/Schools/Colleges
This Code builds on recent changes especially in relation to the Ofsted inspection framework for schools and the new funding arrangements for schools which were implemented in April 2013. Improving outcomes for all and setting high expectations for children and young people with SEN and all teachers are teachers of children with SEN are two cornerstones upon which good practice is based in schools. This section reiterates that the majority of children with SEN should have the choice of being included in mainstream education and the majority will be seen as having Additional Educational Needs (AEN) and be supported from within the school's own delegated resources. As is the case now a minority will have a specialist assessment and be provided through an Education Health & Care Plan.

3.17 Assessments that lead to Education Health & Care Plans
Statutory assessments of education, health and care needs will take place for those few children and young people with complex SEN. Most (but not all) will then lead to an Education, Health & Care Plan (EHC). Timescales for the whole process will be reduced to a maximum of 20 working weeks (currently it is 26 weeks). There are time scales for elements throughout the process. There are no requirements for national reporting on separate aspects but if not met parents and carers have the right to complain. Therefore our systems must be able to track progress in the same manner that operates for the present SEN IT work flow.

3.18 The Code proposes giving the right to professionals from outside of education in partnership with parents to request an assessment. It also intends to allow young adults who are competent to make such requests themselves too. However the criteria the LA must consider when deciding whether an assessment is necessary is similar to the present Code with the addition of considering the circumstances for a young person of 18 years + and whether staying in education would help them make a successful transition into adult life.

3.19 The Code proposes that LA must seek advice for an EHC assessment from the same range of services as currently however it puts greater responsibilities on non-education services to participate.

3.20 For young people aged 16-25 the Code states that they may request an assessment. It acknowledges that some may not need this as it is not in their interest to continue their education. It also makes clear that some young adults with complex needs which are primarily health or social care may not need an EHC assessment and are best provided by continuing Adult Health or Social Care provision.

3.21 Reference is also made to transport and personal budgets. Transport should only be included in the EHC plan in those exceptional cases where the child has specific transport needs as LAs will have transport polices applying to all children with SEN and should not be used to limit parental choice of school. Transport costs may be provided as part of a personalised budget.

3.22 A personal budget is the amount of money identified by each commissioner to deliver all or some of the provisions set out in the EHC plan covering health, care and educational provision. Parents & YP can request a personal budget once an EHC plan is established. Personal budgets may include funding from health, social care and education sources either pooled generally or case specific.

3.23 A personal social care budget:
This refers to the budget that will be made available if it is clear that a young person or child is assessed as needing additional and individual support at home and when out and about in the local and wider community.

3.24 A personal health budget:
This refers to the budget that will be made available should a young person or child have complex, long-term and/or a life-limiting condition/s. A personal health budget may also be made available to help with equipment costs or other health services. Children, who are supported through 'Continuing Care' funding, will have the right to request a personal health budget from April 2014. From August 2013, the NHS has the legal power to give direct payments.

3.25 A personal SEN budget:
This is a sum of money made available by a local authority because it is clear that without this additional (*top-up*) funding it will not be possible to meet the child's learning support needs. The school/college involved will already have funding for learning support across the school; only pupils or students with more complex learning support needs are likely to need a personal SEN budget. In some circumstances the head teacher /principal and school or college/learning provider may choose to offer some funding towards a personal SEN budget; this will always be the decision of the head teacher. Personal budgets must not be used to fund a school place.

3.26 Resolving Disputes
The emphasis is on early resolution. The LA & CCG are expected to work together to resolve disputes. At the moment when this fails parents or young people can appeal to SEND Tribunals. In future there is a possibility that CYP or their families could appeal against **health offers or provisions to SEND Tribunals**. It will also be mandatory for the LA to make an offer of independent mediation which it must commission from Disagreement resolution services (DRS). The LA must make sure the service and the way it works available to parents, operatives are suitably qualified and aware of the SEN process.

3.24 At present the national frameworks mean Health Education and Social Care appeals systems are separate. Where they relate to SEN they are likely to be aligned so that wherever possible they are simpler and clearer for families.

3.26 Joint Commissioning
Local governance arrangements **must** be established which ensure clear ownership and accountability across SEN commissioning. They **must** be robust enough to ensure that all partners are clear about who is responsible for delivering what, who the decision makers are in education, health and social care, and how partners will hold each other to account in the event of a dispute. It is important for elected members and chief executives across education, health and social care to demonstrate leadership for integrated working. Arrangements for children and young people with SEN should be specifically accountable to councillors and senior commissioners. It should be clear who can make decisions both operationally (e.g. deciding what provision should be put in an EHC plan) and strategically (e.g. what provision will be commissioned locally, exercising statutory duties).

3.27 While the details of which services should be commissioned should be agreed locally, the local authority and its partner CCGs **must** make arrangements for agreeing key issues outline above. These include;

The range of provision reasonably required by local children and young people with SEN;

- How provision will be secured and by whom; what advice and information is to be provided about provision and by whom and to whom it is to be provided;
- How complaints about education, health and social care provision can be made and are dealt with; and
- Procedures for ensuring that disputes between local authorities and CCGs are resolved as quickly as possible.
- Partners should also consider how they will respond to children and young people who need to access services swiftly.

3.28 Joint commissioning arrangements **must** include all education, health and care provision which has been assessed as being needed to support children and young people with SEN in the area. The services covered will include specialist support and therapies, such as clinical treatments and delivery of medications, speech and language therapy, occupational therapy, physiotherapy, a range of nursing support, specialist equipment, wheelchairs and continence supplies. They could include highly specialist services needed by only a small number of children which are commissioned centrally by NHS England (for example augmentative and alternative communication systems, or provision for young offenders in the secure estate). They can also include provision delivered by the private or voluntary sectors: voluntary organisations often offer services which are more responsive and locally acceptable to the people who use them. CCGs must work with their local authority partners to

ensure that the right services are in place locally to meet the needs of the population. These services will be included in the local offer.

3.29 For social care, services will include any support assessed as being reasonably required by the learning difficulties and disabilities which result in the child or young person having special educational needs. This can include any services assessed under an early help assessment and/ or under section 17 or section 47 of the Children Act 1989 or assessments under adult care provisions. It can also include services for parents and carers which will support the child's outcomes such as mental health support.

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1 The SEN Reforms will have resource implications, much of which will involve reprioritising available resources. The Department for Education has, however, acknowledged that there will be implementation costs and to assist with those costs, they have provided a one-off grant in 2014/14 of £0.579m, which can be used to recognise the programmes of change underway in SEN or to best meet local need.

4.2 The project board will identify any on-going implications of reforms. Most of the direct costs of providing support for pupils with Special Educational Needs are funded from the Schools Budget (Dedicated Schools Grant). The new ways of working would be factored into budget and service planning cycles for the Schools Budget and Authority's General Fund budget (ie as part of the Medium Term Financial Plan) for future years.

5. LEGAL COMMENTS

5.1 The Children and Families Bill 2013 ("the Bill") (which will become the Children and Families Act 2014) will replace the existing SEN legislation. A new SEN Code of Practice together with a number of statutory Regulations will also be introduced to support the legislative changes. The report outlines the changes required in practice and development of new systems in order to implement the changes, including joint commissioning. Though it should be noted that many of the provisions replicate the current system, the Bill is due to receive Royal Assent (in Spring) and implementation of the proposed changes will commence from September 2014 with a transitional programme of implementation dates. As the Bill may still be altered the numbering of sections referred to below may change.

5.2 Part 3 of the Bill introduces a new single system from birth to 25 for all children and young people with SEN and their families. The new arrangements combine the current separate arrangements for children in schools and young people in post-16 institutions and training up to the age of 25 and provides for an integrated Education, Health and Care (EHC) Plan to replace the statement of Special Educational Needs (SEN). The Bill also

removes the separate treatment of local authority maintained schools and academies under SEN legislation.

5.3 The Bill retains the central role of the local authority in identifying, assessing, and securing the educational provision for children and young people with SEN. Under section 19 the local authority must follow four guiding principles.

These are that the local authority must:

- Listen to the views, wishes and feelings of children, young people and parents;
- Ensure children, young people and parents participate in decision-making;
- Provide the necessary information and support to help children, young people and their parents participate in those decisions; and
- Support children, young people and parents to help children and young people can achieve the best possible educational and other outcomes preparing them effectively for adulthood.

5.4 The Bill introduces a new requirement for local authorities and health services to commission education, health and social care services jointly. This includes arrangements for considering and agreeing what advice and information is to be provided about education, health and care provision, and by whom, to whom and how such advice and information is to be provided. Clinical Commissioning Groups (CCGs) must comply with the health service requirements in EHC plans.

5.5 The current definitions of SEN and special educational provision are broadly retained and extended to include young persons in education or training under the age of 25 (s.20). A child or young person has special educational needs if he or she has a learning difficulty or disability which calls for special educational provision to be made for him or her. Under what is currently section 21 of the Bill health and social care provision which educates or trains a child or young person is to be treated as special educational provision. Children with disabilities are not included automatically in the definition of special educational needs although they may also have SEN (see s.37).

5.6 A local authority must exercise its functions with a view to securing that it identifies all children and young people in its area who have or may have SEN or a disability (s.22), and is “responsible” for them when the authority has identified them or they have been brought to the authority’s attention by a health service body if below compulsory school age (s.23). A local authority is responsible for all children or young person who it has identified as having SEN, or have been brought to the local authority’s attention as may be having special educational needs (s.24).

5.7 The local authority must work with health and social care services to ensure 'the integration of educational provision and training provision' where this promotes the well-being of children with SEN or a disability and improves the quality of special educational provision for them (s.25). The local authority and its partner commissioning bodies (the local CCGs and where relevant the NHS Commissioning Board) must make joint commissioning arrangements about education, health and care provision to be secured for children and young people with special educational needs and those who have a disability (s.26).

5.8 Joint Commissioning Arrangements 'must include arrangements for considering and agreeing' (although there is no duty to agree) EHC provision 'reasonably required' by the learning difficulties and disabilities of children and young people having SEN. Joint Commissioning Arrangements must include the EHC provision for children and young people with disabilities in the local authority area who do not have special educational needs. The arrangements must include what, and by whom, EHC provision is to be secured, what advice and information is to be provided and by whom, how complaints are to be dealt with, and how disputes between the commissioning partners are to be resolved. The parties to the commissioning arrangements must have regard to the arrangements and keep the arrangements under review. The local authority and NHS commissioning bodies must have regard to the Joint Strategic Needs Analysis prepared by the local authority and the Health and Wellbeing Strategy agreed by the Health and Wellbeing Board.

5.9 A local authority must keep under review the local special educational provision and consider the extent that it is meeting the needs of the children and young people for whom it is responsible (s.27). The local authority must work with schools and other education providers to keep this provision under review. In carrying out these and other functions, the local authority must co-operate with a range of local partners including maintained schools and academies, further education bodies, shire districts (for County Councils), and CCGs, and in turn, they must co-operate with the local authority in the exercise of the local authority's functions (s.28). Local authorities must ensure their officers co-operate with each other (including those who work in children's social care). Similarly, each educational institution must cooperate with the local authority in the exercise of the educational institution's functions (s.29).

5.10 A local authority must publish a "local offer" of services it expects to be available for children and young people with special educational needs (s.30). The details of what must be included as part of the local offer is explained in the body of the report. The new provisions require greater co-operation between local authorities and a wide range of partners, including schools, Academies, colleges, other local authorities and services responsible for providing health and social care.

5.11 The Bill requires local authorities to involve parents, children and young people in reviewing and developing provision for those with SEN; and introduces a more streamlined assessment process for those with more

severe and complex needs, integrating education, health and care services and involving children, young people and their parents.

5.12 The provisions on EHC plans are based on the current legislation for statements of special educational needs (s.33) including the assumption that a child with a Plan is educated in a mainstream school. If following an EHC assessment (s.36), the local authority decides to secure EHC provision using a plan (s.37 onwards) then the local authority must secure provision in a mainstream institution 'unless it is incompatible with (a) the wishes of the children's parent or the young person, or (b) the provision of efficient education for others'. In determining whether mainstream education for a child with an EHC Plan is 'incompatible' with the provision of efficient education, the local authority will need to demonstrate that 'no reasonable steps' can be taken 'to prevent the incompatibility'. An EHC needs assessment may be requested by a child's parents, a young person or an educational institution (s.36). The local authority may carry out an EHC needs assessment when it is responsible for a child who has, or may have, SEN under s.24. Details of the specific requirements are set out in the report. If required by the EHC needs assessment, the LA must secure that an EHC Plan is prepared and subsequently maintained (s.37). As under the current provisions, a claim for judicial review will lie if this duty in not complied with.

5.13 Section 49 sets out the provisions on personal budgets and direct payments. The local authority must prepare a 'personal budget' if requested by a child's parents or young person. The personal budget is the amount specified or proposed to be specified in the EHC plan with the money being paid to the parents or young person. Provision is made for 'direct payments' where the local authority pays any fees etc. with the consent of the parents or young person. Details of how personal budgets will operate will be set out in Regulations.

5.14 The new provisions promote mediation to resolve disagreements. As under the current regime, parents may appeal to the First-tier Tribunal against certain matters including decision not to do an EHC needs assessment, a decision not to secure an EHC plan following an assessment, and once a plan is finalised about the content of the plan, re-assessment, amendment and ceasing (s.51). Regulations may set out other grounds of appeal to the Tribunal. It is a criminal offence not to comply with a decision of the Tribunal. A right to mediation is provided in s.52. Although, participation in mediation will not be a requirement of appealing to the Tribunal, the local authority must inform the parent or young person of their right to mediation, and there are different routes for health care mediation (s.53) and educational and social care mediation (s.54). If mediation is sought on health care issues, the local authority must be informed about the health care provision the parent wishes to see in the plan. The rules about how mediation operates are found in s.56 and the mediation will be conducted by a mediation adviser (s.55).

5.15 The local authority must put in place arrangements for avoiding or resolving disputes between the local authority or school or other educational institution

and a child's parents or young person with an EHC plan (s.57). An independent person must be appointed to resolve the dispute. Health service bodies are included in the dispute resolution procedure.

5.16 Details of the new SEN Code of Practice (currently in draft) are set out in the report. In carrying out its functions under the new Act the Local Authority must have regard to the Code.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1. By implementing fully the SEN framework the Council will be ensuring that a particular vulnerable group of children and young adults have their needs identified and addressed.

6.2.

7. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

7.1 The report has no direct impact on environmental factors. However the Council's policy of providing a range of appropriate provision locally to meet the complex needs of children with SEN means few young people transported regularly out of the borough.

8. RISK MANAGEMENT IMPLICATIONS

8.1. The project board overseeing the implementation of the SEN reforms has identified risks and the actions needed to ensure that they are addressed.

9. CRIME AND DISORDER REDUCTION IMPLICATIONS

9.1 The proposals in the report do not contribute to the reduction of crime and disorder. However the widening of the duties under the new SEN framework mean that the Council will be responsible for monitoring the delivery of appropriate education health and care provision of those in custody or secure accommodation if they have EHC Plans.

10. EFFICIENCY STATEMENT

10.1 [Reports concerned with proposed expenditure, reviewing or changing service delivery or the use or resources must incorporate an Efficiency Statement. Please refer to the relevant section of the report writing guide.]

Appendices and Background Documents

Appendices

- None

Background Documents

If your report is a decision making report, please list any background documents not already in the public domain including officer contact information.

- None

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Health and Wellbeing Board 24th March 2014	Tower Hamlets Health and Wellbeing Board
Report of the London Borough of Tower Hamlets	**Classification:** Unrestricted
Protocol in support of the relationship between the Tower Hamlets Health and Wellbeing Board, the Tower Hamlets Local Safeguarding Children Board and the Tower Hamlets Local Safeguarding Adults Board	

Lead Officer	Robert McCulloch-Graham
Contact Officers	Charlotte Saini
Executive Key Decision?	No

Executive Summary

The attached protocol sets out the relationship between the Tower Hamlets Health and Wellbeing Board and two multi agency safeguarding boards: the Local Safeguarding Children's Board and the Safeguarding Adults Board.

The protocol recognises the importance of safeguarding in health, and vice versa. It has been designed to set out formally the influence the safeguarding boards will have with the Health and Wellbeing Board and the Health and Wellbeing Board with the Safeguarding Boards. The protocol sets out recommended annual timescales for sharing of plans and priorities.

Recommendations:

The Health and Wellbeing Board is recommended to:

1. Agree the attached Protocol in support of the relationship between the Tower Hamlets Health and Wellbeing Board, the Tower Hamlets Local Safeguarding Children Board and the Tower Hamlets Local Safeguarding Adults Board

2. Note the timescales for sharing for plans and priorities set out in the protocol and below.

1. REASONS FOR THE DECISIONS

1.1 Understanding and planning for safeguarding in health is key to achieving the best outcomes for the residents of Tower Hamlets. With the formal establishment of the HWBB, it is therefore timely to agree a protocol for the ongoing relationship between the HWBB and the two Safeguarding Boards, ensuring that each Board is able to comment on safeguarding and health elements of health and safeguarding plans, and to feed into future priority setting.

2. ALTERNATIVE OPTIONS

2.1 The alternative option is to not have a protocol between the three boards. This option is not recommended as there is a risk that without the protocol safeguarding/health elements may not receive the full and regular consideration they are due.

3. DETAILS OF REPORT

3.1 Health and Wellbeing Boards (HWBB) were established by the Health and Social Care Act 2012. They are intended to be a forum where key leaders from the health and care system work together to improve the health and Wellbeing of their local population and reduce health inequalities.

3.2 The Children Act 2004 required each local authority to establish a Local Safeguarding Children Board (LSCB). It is the key statutory mechanism for agreeing how the relevant organisations in each local area will co-operate to safeguard and promote the welfare of children and to ensure that these agencies are effective. It operates under guidelines known as 'Working Together to Safeguard Children'; the latest version came into effect from 15th April 2013.

3.3 Safeguarding Adult Boards (SABs) are not currently statutory bodies but will assume this status with the passage of the forthcoming Care Bill. Currently Boards operate within the framework promoted by 'No Secrets' which was published by the Department of Health and the Home Office in March 2000 and by 'Safeguarding Adults' which was published by the then Association of Directors of Social Services in October 2005. In March 2013, NHS England published a document 'Safeguarding Vulnerable People in the Reformed NHS- Accountability and Assurance Framework' which gave guidance on the relationships between the Safeguarding Boards and the HWBB (section 4.2).

3.4 Following discussions at between the Independent Chair of Tower Hamlets Safeguarding Adults Board, the Independent Chair of the Tower Hamlets Local Safeguarding Children's Board and the Chair of the Tower Hamlets Health and Wellbeing Board, it was agreed at the September 2013 Shadow HWBB that there should be a formal agreement outlining this relationship.

3.5 This Tower Hamlets Protocol sets out the distinct roles and responsibilities of the Boards, the interrelationships between them in terms of safeguarding, and wellbeing and the means to ensure effective co-ordination between the Boards.

3.6 This agreement will be discussed at the next meetings of both Safeguarding Boards and then circulated to the HWB for ratification.

3.7 Key timescales to note within the protocol are as follows:

- Between April and July each year, the Safeguarding Boards will share their proposed business plans with the Health and Wellbeing Board for challenge.

- Between May and September each year, the Health and Wellbeing Board will present to the Safeguarding Boards the review of the Health and Wellbeing Strategy, an update on the JSNA with the proposed priorities and objectives to enable the safeguarding boards to challenge performance of the Health and Wellbeing Board.

- Between September and December each year, the Independent Chairs of the two Safeguarding Boards will present to the Health and Wellbeing Board their annual reports outlining performance against business plan objectives in the previous financial year. This will be supplemented by a position statement on the Boards' performance in the current financial year. This will provide the opportunity for the Health and Wellbeing Board to challenge the performance of the Boards, to draw across data to be included in the JSNA and to reflect on key issues that may need to be incorporated in any refresh of the Health and Wellbeing Strategy.

4. COMMENTS OF THE CHIEF FINANCE OFFICER

4.1. There are no financial implications arising from this report, which deals with governance arrangements.

5. LEGALCOMMENTS

5.1. The attached Protocol sets out the distinct roles and responsibilitiesarising from the statutory functions of the Health and Wellbeing Board ("**HWB**") and Local Safeguarding Children's Board ("**LSCB**") and the functions of the Safeguarding Adults Board("**SAB**"), which is soon to be placed on a statutory basis under the Care Bill. The Protocol may need to be reviewed for statutory compliance once the final version of the Care Bill is enactedlater this year. The legal functions of these Boards are set out in detail in the body of the Protocol.

5.2. This Protocol is consistent with the general policy, reflected in the Health and Social Care Act 2012, of giving HWBs responsibility for joint health and wellbeing strategies and the joint strategic needs assessment. Importantly,

the Protocol recognises the separate legal responsibilities of each of the Boards, and does not subsume the LSCB or SAB within the role of the HWB but gives each a safeguarding and scrutiny role towards each other, to improve accountability.

5.3. The HWB is asked to agree the Protocolat its meeting on 24 March 2014. This agreement is within the terms of reference of the HWB agreed by the Mayor in Cabinet on 4 December 2013, which include the following functions –

- To encourage integrated working between persons who arrange for the provision of any health or social services in Tower Hamlets for the advancement of the health and wellbeing of the people in Tower Hamlets.
- To provide advice, assistance or other support in order to encourage partnership arrangements under Section 75 of the NHS Act 2006.
- To identify needs across Tower Hamlets and publish and refresh the Joint Strategic Needs Assessment ("**JSNA**") so that future commissioning/policy decisions are based on evidence.
- To have oversight of the quality, safety and performance mechanisms operated by member organisations of the Board, and the use of relevant public sector resources across a wide spectrum of services and interventions, with greater focus of integration across outcomes spanning health care, social care and public health. Areas of focus to be agreed by the Board from time to time by members of the Board as part of work planning for the Board.

5.4. Given that the Protocol is focussed on achieving better service integration and through effective coordination in delivering and evaluating safeguarding strategy between the Boards and an integrated approach to the JSNA, it is reasonable for the HWB to be asked to endorse the Protocol. It falls within the HWB functions of encouraging integration and supporting partnerships under section 75 of the NHS Act 2006 and ensuring quality, safety and performance mechanism are operated by members of the Board. As the HWB has statutory status, due regard should be given to its decision making authority within its terms of reference.

5.5. There are no significant financial implications for the Council, requiring an executive decision by the Mayor and as this matter falls within the Terms of Reference of the HWB agreeing the Protocol is within the remit of the Board.

5.6. When planning for integration of health and social care functions, the Council and its committees must have due regard to the need to eliminate unlawful conduct under the Equality Act 2010, the need to advance equality of opportunity and the need to foster good relations between persons who share a protected characteristic and those who don't. Some form of equality analysis will be required and officers will have to decide how extensive this should be.

6. ONE TOWER HAMLETS CONSIDERATIONS

6.1 The are no specific equality and diversity implications, although specific consideration will be given to children's safeguarding and safeguarding of vulnerable adults.

7. SUSTAINABLE ACTION FOR A GREENER ENVIRONMENT

7.1 N/A

8. RISK MANAGEMENT IMPLICATIONS

8.1 The proposals in the report, and set out in the protocol, will enhance influence and cross-board working, mitigating the risk that strategies and plans around health and safeguarding are produced in silo and without regard to each other.

9. CRIME AND DISORDER REDUCTION IMPLICATIONS

9.1 No specific implications.

10. EFFICIENCY STATEMENT

10.1 No specific implications, establishing formalised channels of work between the Boards should foster more focused outcomes around health and wellbeing and safeguarding which in turn could improve efficiency and value for money.

Appendices and Background Documents

Appendices

i. Protocol in support of the relationship between the Tower Hamlets Health and Wellbeing Board, the Tower Hamlets Local Safeguarding Children Board and the Tower Hamlets Local Safeguarding Adults Board

ii. Tower Hamlets Health and Wellbeing Board Terms of Reference

iii. Tower Hamlets Local Children's Safeguarding Board Terms of Reference

iv. Objectives and core essentials of the Tower Hamlets Safeguarding Adults Board

Background Documents
None.

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APPENDIX 1

Protocol in support of the relationship between the Tower Hamlets Health and Wellbeing Board, the Tower Hamlets Local Safeguarding Children Board and the Tower Hamlets Local Safeguarding Adults Board

March 2014

1. Introduction

1.1 Health and Wellbeing Boards (HWBB) were established by the Health and Social Care Act 2012. They are intended to be a forum where key leaders from the health and care system work together to improve the health and Wellbeing of their local population and reduce health inequalities.

1.2 The Children Act 2004 required each local authority to establish a Local Safeguarding Children Board (LSCB). It is the key statutory mechanism for agreeing how the relevant organisations in each local area will co-operate to safeguard and promote the welfare of children and to ensure that these agencies are effective. It operates under guidelines known as 'Working Together to Safeguard Children'[1]; the latest version came into effect from 15th April 2013.

1.3 Safeguarding Adult Boards (SABs) are not currently statutory bodies but will assume this status with the passage of the forthcoming Care Bill. Currently Boards operate within the framework promoted by 'No Secrets'[2] which was published by the Department of Health and the Home Office in March 2000 and by 'Safeguarding Adults' which was published by the then Association of Directors of Social Services in October 2005[3].In March 2013, NHS England published a document 'Safeguarding Vulnerable People in the Reformed NHS- Accountability and Assurance Framework'[4] which gave guidance on the relationships between the Safeguarding Boards and the HWBB (section 4.2).

1.4 Following discussions between the Independent Chair of Tower Hamlets Safeguarding Adults Board, the Independent Chair of the Local Safeguarding Children's Board and the Chair of the Health and Wellbeing Board, it was agreed that there should be a formal agreement outlining this relationship.

1.5 This Tower Hamlets Protocol sets out the distinct roles and responsibilities of the Boards, the interrelationships between them in terms of safeguarding, and wellbeing and the means to ensure effective co-ordination between the Boards.

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[1] http://www.education.gov.uk/aboutdfe/statutory/g00213160/working-together-to-safeguard-children

[2] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/194272/No_secrets__guidance_on_developing_and_implementing_multi-agency_policies_and_procedures_to_protect_vulnerable_adults_from_abuse.pdf

[3] http://www.adass.org.uk/images/stories/Publications/Guidance/safeguarding.pdf

[4] http://www.england.nhs.uk/wp-content/uploads/2013/03/safeguarding-vulnerable-people.pdf

1.6 This agreement will be discussed at the next meetings of both Safeguarding Boards and then circulated to the Health and Wellbeing Board for ratification.

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2. The purpose of and principles of the Health and Wellbeing Board

2.1 Each top tier and unitary authority must have its own Health and Wellbeing Board.The Tower Hamlets Health and Wellbeing Board has agreed terms of reference which outline its underlying principles, keyresponsibilities, its role, purpose and membership. This document is included at Appendix 1.

3. What are the functions of Health and Wellbeing Boards?

3.1 Health and Wellbeing boards have strategic influence over commissioning decisions across health, public health and social care through their Joint Strategic Needs Assessment (JSNA) and the development of their Health and Wellbeing strategy.

3.2 Boards are intended to strengthen legitimacy by involving democratically elected representatives and patient representatives in commissioning decisions alongside commissioners across health and social care. The boards also provide a forum for challenge, discussion, and the involvement of local people.

3.3 Boards will bring together Clinical Commissioning Groups and councils to develop a shared understanding of the health and wellbeing needs of the community. They will undertake the JSNA and develop a joint strategy for how these needs can be best addressed. This will include recommendations for joint commissioning and integrating services across health and care.

3.4 Through undertaking the JSNA, the Board will drive local commissioning of health care, social care and public health and create a more effective and responsive local health and care system. Other services that impact on health and wellbeing such as housing and education provision will also be addressed.

4. The Purpose of the Tower Hamlets Local Safeguarding Children Board (LSCB)

4.1 Section 14 of the Children Act 2004 sets out the objectives of LSCBs, which are:

(a) to coordinate what is done by each person or body represented on the Board for the purposes of safeguarding and promoting the welfare of children in the area;and
(b) to ensure the effectiveness of what is done by each such person or body forthose purposes

4.2 Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out that thefunctions of the LSCB in relation to the above objectives under section 14 of the Children Act2004, are as follows:

- developing policies and procedures for safeguarding and promoting the welfare ofchildren in the area of the authority, including policies and procedures in relation to:

- the action to be taken where there are concerns about a child's safety or welfare,including thresholds for intervention;
- training of persons who work with children or in services affecting the safety andwelfare of children;
- recruitment and supervision of persons who work with children;
- investigation of allegations concerning persons who work with children;
- safety and welfare of children who are privately fostered
- co-operation with neighbouring children's services authorities and their Boardpartners;
- communicating to persons and bodies in the area of the authority the need to safeguardand promote the welfare of children, raising their awareness of how this can best be doneand encouraging them to do so;
- monitoring and evaluating the effectiveness of what is done by the authority and theirBoard partners individually and collectively to safeguard and promote the welfare of childrenand advising them on ways to improve;
- participating in the planning of services for children in the area of the authority; and
- undertaking reviews of serious cases and advising the authority and their Board partnerson lessons to be learned

4.3 The role of the LSCB is to scrutinise and challenge the work of agencies both individuallyand collectively. The LSCB is not operationally responsible for managers and staff in theconstituent agencies.

5. Tower Hamlets Safeguarding Adults Boards (SAB)

5.1 The focus of the work of Safeguarding Adults Boards is the prevention of harm to'vulnerable' adults. The forms of abuse which the Board aims to prevent and address are:

- physical abuse, sexual abuse, psychological abuse, financial or material abuse, neglect oracts of omission, discriminatory abuse.

5.2 The role of the SAB is to ensure effective safeguarding arrangements are in place in both the commissioning and provision of services to vulnerable adults by individual agencies andto ensure the effective interagency working in this respect.

5.3 The Board has identified agreed objectives and priorities for its work which include clearpolicy, procedural and practice arrangements, mechanisms to secure coordination ofactivities between agencies, the provision of training and workforce development in supportof safeguarding and quality assurance and performance management arrangements to testthe effectiveness of safeguarding and the impact of the Board.

5.4 Effective communication and engagement between the Boards. Safeguarding is everyone's business. As such, all key strategic plans, whether they beformulated by individual agencies or by partnership forums, should include safeguarding asa cross-cutting consideration to ensure that existing strategies and service delivery, as well asemerging plans for change and improvement, include effective safeguarding arrangements.

6. Interrelationships

6.1 The Health and Wellbeing Strategy is a key commissioning strategy for the delivery ofservices to children and adults across the Borough and so it is critical that, in compilingdelivering and evaluating the strategy, there is effective interchange between the Health andWellbeing Board and the two Safeguarding Boards.Specifically there need to be formal interfaces between the Health and Wellbeing Board and the Safeguarding Boards at key points including:

- The needs analyses that drive the formulation of the Health and Wellbeing Strategy and
- The Safeguarding Boards' annual business plans. This needs to be reciprocal in natureassuring that Safeguarding Boards' needs analyses are fed into the JSNA and that theoutcomes of the JSNA are fed back into safeguarding boards' planning;
- Ensuring each Board is regularly updated on progress made in the implementation of theHealth and Wellbeing Strategy and the individual Board plans in a context of mutual challenge;
- Annually reporting evaluations of performance on plans to provide the opportunity forreciprocal scrutiny and challenge and to enable Boards to feed any improvement anddevelopment needs into the planning process for future years' strategies and plans.

6.2 Whilst currently there is no statutory requirement to secure a formal relationship between theHealth and Wellbeing Board and the safeguarding boards there is draft guidance steeringinthis direction that may become a requirement.For example in Working Together 2013 page 51 states "The NHS Commissioning Board (now NHS England)will also lead and define improvement in safeguarding practice andoutcomes and should also ensure that there are effective mechanisms for LSCBs and Healthand Well-Being boards to raise concerns about the engagement and leadership of the localNHS."

6.3 The guidelines also stipulate that the LSCB annual report should be submitted to the Chairof the HWBB. It is probable that these requirements will be replicated for Adult SafeguardingBoards when they are made statutory in the next year or so. The Tower Hamlets Health and Wellbeing Board received both safeguarding annual reports in September 2013 and will continue to receive these on an annual basis.

6.4 The opportunities presented by a formal working relationship between the Tower Hamlets Healthand Wellbeing Board and the two safeguarding boards can be summarised as follows:

- Securing an integrated approach to the JSNA, ensuring comprehensive safeguarding data analysis in the JSNA
- Reflecting safeguarding issues raised by the LSCB and SAB business plans with the HWB Strategy and related priority setting
- Ensuring safeguarding is ''everyone's business'', reflected in the public health agenda

- Evaluating the impact of the HWB Strategy on safeguarding outcomes, and ofsafeguarding on wider determinants of health outcomes (such as domestic abuse)
- Cross Board scrutiny and challenge and ‘’holding to account’’ the Wellbeing Board for embedding safeguarding, and the Safeguarding Boards for overall performance andcontribution to the HWB Strategy.

7. Arrangements to secure co-ordination between the Boards

7.1 In order to realise these opportunities, it is proposed that the following arrangements would be put in place to ensure effective co-ordination and coherence in the work of the threeBoards.

i. Between April and July each year, the Safeguarding Boards will share their proposed business plans with the Health and Wellbeing Board for challenge.

ii. Between May and September each year, the Health and Wellbeing Board will present to the Safeguarding Boards the review of the Health and Wellbeing Strategy, an update on the JSNA with the proposed priorities and objectives to enable the safeguarding boards to scrutinise and challenge performance of the Health and Wellbeing Board.

iii. Between September and December each year, the Independent Chairs of the two Safeguarding Boards would present to the Health and Wellbeing Board their annual reports outlining performance against business plan objectives in the previous financial year. This would be supplemented by a position statement on the Boards’ performance in the current financial year. This would provide the opportunity for the Health and Wellbeing Board to challenge the performance of the Boards, to draw across data to be included in the JSNA and to reflect on key issues that may need to be incorporated in any refresh of the Health and Wellbeing Strategy.

8. Conclusion

8.1 The roles of the LSCB and LSAB in relation to the HWB would be one of equal partners underpinned by this protocol sharing influence and mutual challenge on safeguarding and health across the lifecourse. Each is accountable to each other and the LSCB has astatutory responsibility to challenge and hold agencies to account for the safety of Tower Hamlets’ children. A similar responsibility will be given in law to the LSAB. This protocol is designedto ensure these functions are discharged effectively in Tower Hamlets without duplicating functionsor creating additional structures.

Supporting Documents

- Tower Hamlets Health and Wellbeing Board Terms of Reference
- Tower Hamlets LSCB Terms of Reference
- Objectives and core essentials of the Tower Hamlets Safeguarding Adults Board

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APPENDIX 2

Tower Hamlets Health and Wellbeing Board – Terms of Reference, Quorum and Membership

The Health and Wellbeing Board will lead, steer and advise on strategies to improve the health and wellbeing of the population of Tower Hamlets. It will seek to do this through joint work across services in the Borough and the greater integration of health and social care as well as with those accessing services that can help to address the wider determinants of Health. The Board continues to support the ambitions of the Tower Hamlets Partnership outlined within the Tower Hamlets Community Plan.

The Health and Wellbeing Board has the following functions:

1. To have oversight of assurance systems in operation
2. To encourage integrated working between persons who arrange for the provision of any health or social services in Tower Hamlets for the advancement of the health and wellbeing of the people in Tower Hamlets.
3. To provide advice, assistance or other support in order to encourage partnership arrangements under Section 75 of the NHS Act 2006.
4. To encourage those who arrange for the provision of any health-related services in Tower Hamlets (e.g. services related to wider determinants of health, such as housing) to work closely with the HWB.
5. To encourage persons who arrange for the provision of any health or social care functions in Tower Hamlets and those who arrange for the provision of health-related services in Tower Hamlets to work closely together.
6. To identify needs and priorities across Tower Hamlets and publish and refresh the Tower Hamlets Joint Strategic Needs Assessment (JSNA) so that future commissioning/policy decisions are based on evidence.
7. To prepare the Joint Health and Wellbeing Strategy.
8. To develop, prepare, update and publish the local pharmaceutical needs assessments.
9. To be involved in the development of any CCG Commissioning Plan that applies to Tower Hamlets and to give its opinion to the CCG on any such proposed plan.
10. To communicate and engage with local people on how they could achieve the best possible quality of life and be supported to exercise choice and control over their personal health and wellbeing. This will involve working with Local HealthWatch to make sure there's a continuous dialogue with the public to ensure services are meeting need.
11. Consider and promote engagement from wider stakeholders.
12. To have oversight of the quality, safety, and performance mechanisms operated by member organisations of the Board, and the use of relevant public sector resources across a wide spectrum of services and interventions, with greater focus on integration across outcomes spanning health care, social care and public health. Areas of focus to be agreed from time to time by members of the Board as part of work planning for the Board.
13. Such other functions delegated to it by the Local Authority.
14. Such other functions as are conferred on Health and Wellbeing Boards by enactment

Quorum
The quorum of the Board in the Terms of Reference is a quarter of the membership including at least one Elected Member of the Council and one representative from the NHS Tower Hamlets Clinical Commissioning Group.

Membership The membership of the Board is as follows:

Chair

- Mayor of London Borough of Tower Hamlets (LBTH)

Vice Chair

- Cabinet Member for Health and Wellbeing

Elected Representatives of LBTH

- Cabinet Members for Health & Wellbeing and Children's Services (2)
- Cabinet Member for Resources
- Executive Advisor on Adult Social Care
- Non-executive majority group councillor nominated by Council

Local Authority Officers- LBTH

- Corporate Director - Education, Social Care and Wellbeing (Director of Adult Social Services and Children Services) - LBTH
- Director of Public Health - Tower Hamlets

Local HealthWatch

- Chair of local Healthwatch

NHS (Commissioners)

- Chair - NHS Tower Hamlets Clinical Commissioning Group
- Chief Operating Officer – NHS Tower Hamlets Clinical Commissioning Group (CCG)

Co-opted Members (Non-Voting)

- Health Providers
- Chief Operating Officer - Barts Health
- Chair of Tower Hamlets - Council for Voluntary Services

- Deputy Chief Executive - East London and the Foundation Trust

- Representative from the Housing Forum.
- Chair of the Integrated Care Board
- The Young Mayor

Stakeholders that may attend the Board from time to time but are not members:

- Representative of NHS England
- Chairs of Tower Hamlets Safeguarding Boards (Adults and Childrens).
- Chair of the LBTH Health Scrutiny Panel
- Local Liaison Officer for National Commissioning Group.

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Terms of Reference for the Tower Hamlets Local Safeguarding Children Board

October 2011 (updated Feb 2014)

Overall purpose

The Local Safeguarding Children Board (LSCB) established through the Children Act 2004 Section 14.1, is a statutory mechanism for agreeing how the relevant organisations in each local area will co-operate to safeguard and promote the welfare of children, and for ensuring the effectiveness of what they do.

Working Together to Safeguard Children, Chapter 3 (DfE 2013), sets out in detail guidance for LSCBs and their member organisations to follow regarding their role, functions, governance and operational arrangements. The LSCB should coordinate what is done by each person or body represented on the Board and ensure the effectiveness of work undertaken by member organisations through a variety of mechanisms including peer review, self-evaluation, performance indicators and joint audit.

The broad scope of the LSCB is to address:

- Activity that affects all children and aims to identify and prevent maltreatment or impairment of health or development, and ensure children are growing up in circumstances consistent with safe and effective care
- Proactive work that aims to target particular groups
- Responsive work to protect children who are suffering, or likely to suffer, significant harm

Budgets responsible for

To function effectively, the LSCB needs to be supported by its member organisations with adequate and reliable resources. The LSCB budget is funded by contributions made by the Police, Health Agencies (Community, Acute and Mental Health), Probation, CAFCASS, Children's Social Care and Local Authority other. It is the expectation that the majority of funds will be provided by these core partners. The LSCB budget and the statutory contribution* (s15, CA04) made by each member organisation should be reviewed and agreed on an annual basis at the end of the financial year by the Independent LSCB Chair and the LSCB Partners Group.

* *Contribution is considered to be financial payments towards expenditure incurred or in kind through the provision of staff, goods or services.*

Legal Agreements

The LSCB may request personal or other information subject to the Data Protection Act. Currently, Tower Hamlets' LSCB adheres to the scope outlined in the *Information Sharing Guidance for Practitioners and Managers* (DCSF 2008) and the North East London Information Sharing Protocols.

Information sharing with the LSCB will be strengthened with the passage of the Children and Families Bill, which makes provisions for compliance with LSCB requests for 'appropriate' information to be disclosed in order to assist it in the

exercise of its functions. The current local Information Sharing Agreement will need to be reviewed against the Children & Families Bill.

Accountable to

Tower Hamlets' LSCB is accountable for its work to

- The local community
- Constituent agencies
- Overview and Scrutiny Committee
- Secretary of State

Who is accountable to the LSCB?

The following are accountable to the LSCB in relation to the discharge of responsibilities in safeguarding children:

- Children and Families Partnership (in relation to safeguarding activity)
- Health and Wellbeing Board
- MARAC
- MAPPA
- LSCB Partners Group
- LSCB Subgroups:
  - Child Death Overview Panel
  - Case Review / Serious Case Review
  - Quality Assurance & Performance
  - Policy & Information
  - Learning & Development
  - Awareness Raising & Engagement

LSCB Core Functions:

The core functions of an LSCB are set out in regulations and are:

- Developing policies and procedures including those on:
  - action taken where there are concerns about the safety and welfare of a child, including thresholds for intervention;
  - training of people who work with children or in services affecting the safety and welfare of children;
  - recruitment and supervision of people who work with children;
  - investigation of allegations concerning people who work with children;
  - safety and welfare of children who are privately fostered;
  - co-operation with neighbouring children's services authorities (i.e. local authorities) and their LSCB partners;
- Communicating and raising awareness;
- Monitoring and evaluation;
- Participating in planning and commissioning;
- Reviewing the deaths of all children in their areas; and
- Undertaking Serious Case Reviews.

Additional LSCB Tasks:

- To audit and evaluate the effectiveness of local services in protecting and promoting the welfare of children

- To establish standards and performance indicators for the protection of children as required by DfE and within the framework set out in the Children and Young People's Plan (CYPP 2009-2012)

- To encourage and support the development of cooperative working relationships and mutual understanding between agencies and professionals with responsibilities for the welfare and protection of children as identified with the London Child Protection Procedures and the THIS Child

- Participate in the local planning and commissioning of children's services to ensure that they take safeguarding and promoting the welfare of children into account

- To use knowledge gained from research and national and local experience to develop and improve practice and service delivery and to ensure that lessons learned are shared, understood and acted on

- To raise awareness within the wider community of the need to safeguard children prevent harm and explain how the community can contribute to these objectives

- To ensure that single agency and multi-agency training on safeguarding and promoting welfare is provided in order to meet local needs. This covers both training provided by single agency to their staff and multi-agency training where staff from more than one agency train together.

Decision-Making Powers

The LSCB Main Board, consisting of its entire member organisation holds the final mandating authority and will be sought to make key local decisions relating to safeguarding and protection of children.

Outputs

There may be some exceptions, but outputs should include:

- LSCB Annual Review
- Multi-agency case and thematic audits
- Section 11 audits
- Bi-annual conference
- Annual Budget
- Annual Awareness Raising Campaign

Membership

The LSCB Membership was reviewed in January 2014 (see Appendix 1 for full list).

Expectation of Chair and Members

Chair
The Chair is responsible for providing effective leadership of the Board. He/she has a crucial role in securing an independent voice for the LSCB and should have the confidence of all partners.

The Chair and members of the Board are expected to:

- Read papers in advance of meetings, respond to emails and other communications in relation to the work of the LSCB
- Attend meetings, or provide a suitable delegate by notifying the Chair in advance and obtaining agreement to the deputy or alternative representative
- Participate in meetings and vote on decisions as a representative of their organisation or stakeholder group
- Feedback relevant information to their group or organisation
- Represent and promote the work of the LSCB
- Ensure knowledge of national and local safeguarding developments are kept up to date, including their child protection/safeguarding training

Meeting Frequency

Quarterly – January, April, July, September, November
An extraordinary meeting may be added during the year, if necessary

Support

The LBTH Strategy, Policy and Performance team provide business and policy support for the Board including:

- Arranging meetings
- Planning and writing papers
- Coordinating Board papers
- Writing and circulating minutes
- Advising on key policy developments

Relationships and links with other Strategic Bodies

Children and Families Partnership*
Community Safety Partnership*
Health and Wellbeing Board*
London Safeguarding Children Board

* *Memorandum of understanding/ Protocol developed between the LSCB Main Board and these Forums*

APPENDIX 1 - LSCB Membership

NAME	JOB TITLE	EMAIL ADDRESS
Abzal Ali	Targeted Support Manager Youth & Community - LBTH	Abzali.ali@towerhamlets.gov.uk
Alex Nelson	Voluntary Sector Children & Youth Forum Coordinator	alex@vcth.org.uk
Andy Bamber	Service Head - Safer Communities	Andy.bamber@towerhamlets.gov.uk
Ann Roach	Service Manager, Child Protection & Reviewing , LBTH	Ann.roach@towerhamlets.gov.uk
Anne Canning	Service Head, Learning & Achievement, Education, Social Care & Wellbeing, LBTH	Anne.canning@towerhamlets.gov.uk
Claire Lillis	Secondary School Heads Rep (Ian Mikardo Secondary School)	head@ianmikardo.towerhamlets.sch.uk
Cllr Oliur Rahman	Lead Member for Children's Services	Oliur.rahman@towerhamlets.gov.uk
David Galpin	Legal Services – LBTH	David.galpin@towerhamlets.gov.uk
Emily Fieran-Reed	Service Manager, Domestic Violence & Hate Crime, Community Safety - LBTH	Emily.fieran-reed@towerhamlets.gov.uk
Emma Tukmachi (Dr)	GP Representative Tower Hamlets CCG	emmatukmachi@nhs.net
Esther Trenchard-Mabere	Associate Director of Public Health	Esther.trenchard-mabere@towerhamlets.gov.uk
Hannah Falvey (Dr)	CCG Representative	Hannah.falvey@bartshealth.nhs.uk
Helal Ahmed	Voluntary Sector Rep Poplar HARCA	Helal.ahmed@poplarharca.co.uk
Carole Austin (Jessica Juon)	Service Manager for Tower Hamlets, NSPCC	jjuan@nspcc.org.uk
Jan Pearson	Associate Director for Safeguarding Children, ELFT	jan.pearson@eastlondon.nhs.uk
Jackie Odunoye	Service Head, Housing & RSL Rep	Jackie.odunoye@towerhamlets.gov.uk
Jenny Green	Subgroup Chair – L&D Professional Development Manager – HR & Workforce - LBTH	Jenny.a.green@towerhamlets.gov.uk
Kate Gilbert	Interim Assistant - Chief Probation Officer, Probation Trust	kate.gilbert@london.probation.gsi.gov.uk
Khalida Khan	Service Manager Children with Disabilities Service, CSC	Khalida.khan@towerhamlets.gov.uk
Layla Richards	Service Manager Strategy, Policy & Performance - LBTH	layla.richards@towerhamlets.gov.uk
Linda Kim-Newby	Senior Service Manager CAFCASS	Linda.kim-newby@cafcass.gsi.gov.uk

NAME	JOB TITLE	EMAIL ADDRESS
Nick Steward	Director of Student Services Tower Hamlets College	Nick.steward@tower.ac.uk
Owen Hanmer (Dr)	Designated Doctor, Barts Health NHS Trust (Community Services)	owen.hanmer@nhs.net
Robert McCulloch-Graham	Corporate Director, Education, Social Care & Wellbeing – LBTH	Robert.mcCulloch-graham@towerhamlets.gov.uk
Robert Mills	Nurse Consultant for Safeguarding Children & Designated Nurse, Tower Hamlets CCG	rob.mills@towerhamletsccg.nhs.uk
Sally Shearer	Director for Nursing/Safeguarding Children, Barts Health NHS Trust	sally.shearer@bartshealth.nhs.uk
Sam Price (DCI) (Anthea Richards)	Met Police Service – Child Abuse Investigation Team	Sam.l.price@met.police.uk
Sara Haynes	Primary School Heads Rep (Arnhem Wharf)	head@arnhemwharf.towerhamlets.sch.uk
Sarah Baker	Independent LSCB Chair	Sarah.baker19@nhs.net
Sarah Wilson	Director of Specialist Services, ELFT	sarah.wilson@eastlondon.nhs.uk
Steve Liddicott	Service Manager – CSC, LBTH	steve.liddicott@towerhamlets.gov.uk
Stuart Johnson	Service Manager, Youth Offending Service - LBTH	Stuart.johnson@towerhamlets.gov.uk
Wendy Morgan (DCI)	Public Protection Unit, MPS Tower Hamlets	wendy.k.morgan@met.pnn.police.uk

APPENDIX 4

Objectives and core essentials of the Tower Hamlets Safeguarding Adults Board (SAB)

Extract below from Tower Hamlets Safeguarding Adults Board (SAB) – Programme for 2013-14. Agreed formally at SAB meeting 21 May 2013

The draft Care Bill (2013/4), currently in its final parliamentary stages, intends that SABs should operate on a statutory basis whereby:

- Local authorities are responsible for establishing and running Safeguarding Adults Boards.
- Boards must coordinate and ensure the effectiveness of what each of its members does.
- The local authority, Clinical Commissioning Group and chief officer of police must be core members (Boards have the power to determine other appropriate members).
- The Board must publish a strategic plan each financial year setting out how it will protect people at risk of harm and what each member is to do to implement the strategy.
- At the end of the financial year the Board must publish an annual report on its achievements, members' activity and findings from any Safeguarding Reviews during that period.
- It must consult its area's Health Watch and involve the community in preparing the strategy.

In practice Tower Hamlets SAB has been working to most of these principles in recent years**.** In 2013-14 the SAB agree formally to work to these expectations given that most of the elements are already in place.

The SAB additionally agreed on 26 March 2013 that:

The Board needs to be clear about its key role as one of ‘Governance’ – assurance about:

- quality of practice
- compliance with policies and procedures
- quality of commissioning
- performance and quality of outcomes for people who need safeguarding interventions

There need to be clear statements, understood by all Board members and communicated within agencies, and 'owned by all', of SAB Strategy and Priorities. The Board must ensure that there is common understanding of all the essential features of safeguarding adults.

The SAB's Independent Chair stated that the SAB should:

- Ensure all relevant agencies and individuals work together to common policies, procedures and expectations of quality of practice and management - in a positive partnership spirit.

- Take initiatives and respond to events specifically related to:
  - the communities of LBTH
  - learning from individual cases or events

- Be assured that practice and performance fits with policy intentions and statutory requirements on both individual agency and a multi agency basis – holding all agencies and the SAB itself to account

Brian Parrott
Independent Chair, Safeguarding Adults Board
London Borough of Tower Hamlets
February 2014